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Graduate Program in Health Care Administration

The Effect of Claims Processing Work Simplification Initiatives on Network Non-Institutional Professional Claims Processing Time

A Graduate Management Project
Presented To

E.W. Quesenberry, CAAMA
CAPT, MSC, USN
Preceptor

D.G. Dominguez, Ph.D
CDR,MSC, USN
Faculty Reader

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By

Barbara A. Coleman
Lieutenant, MSC, USNR

TRICARE Mid-Atlantic Region 2
Norfolk, Virginia

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14. ABSTRACT

Managed care organizations (MCO) must make every effort to improve the effectiveness of claims processing and reporting or they will risk the loss of member and provider satisfaction and ultimately lose their ability to remain solvent. The status of claims administration has been elevated in light of the fact that somewhere between 73 and 93 percent of all premium dollars are paid out for medical care in capitation and claims payments. An effective MCO will use claims processing data to manage the cost of health care on a case basis and in aggregate. Designing appropriate claims reports is essential to a well-managed healthcare organizations ability to effectively forecast liability trends and institute corrective steps. When TRICARE Managed Care Support Contracts were brought on-line there was no longer a direct contractual relationship between the FI and the government. Consequently, the Departmentof Defense was no longer at risk for either the expenditure of healthcare dollars or the adjudication of claims. Unfortunately, TMA continued to monitor the MCSC as if the government maintained the risk and was overly prescriptive with literally thousands of edits that slowed the claim process down. TRICARE has had claims processing timeliness and accuracy issues since its inception due in large part to the numerous eligibility categories, differing cost shares and benefits, the three health plan options (Prime, Extra, and Standard), and its reliance on data exchanges. TRICARE Management Activity (TMA) recognized that failure to respond immediately to beneficiary and provider concerns regarding claims processing would result in the loss of both patients and network providers. TMA tightened the timeliness standard of 75 percent of claims processed within 21 days to 95 percent of clean claims within 30 days and 100 percent in 60 days. This case study was conducted through review and analysis of the Managed Care Support Contract in TRICARE Mid-Atlantic Region 2, TMA Policy Guidelines, TMA Operations Manual, TMA ADP Manual, Business Objects Users Guide, memoranda, interviews, contractor site-visits and published literature. In addition, data was gathered through structured and unstructured interviews with staff members at PGBA, Tri-Atlantic, TMA, and Lead Agent TRICARE Mid-Atlantic Region 2.

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ABSTRACT

Managed care organizations (MCO) must make every effort to improve the effectiveness of claims processing and reporting or they will risk the loss of member and provider satisfaction and ultimately lose their ability to remain solvent. The status of claims administration has been elevated in light of the fact that somewhere between 73 and 93 percent of all premium dollars are paid out for medical care in capitation and claims payments. An effective MCO will use claims processing data to manage the cost of health care on a case basis and in aggregate. Designing appropriate claims reports is essential to a well-managed healthcare organization's ability to effectively forecast liability trends and institute corrective steps.

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This case study was conducted through review and analysis of the Managed Care Support Contract in TRICARE Mid-Atlantic Region 2, TMA Policy Guidelines, TMA Operations Manual,

TMA ADP Manual, BusinessObjects User's Guide, memoranda, interviews, contractor site-visits and published literature. In addition, data was gathered through structured and unstructured interviews with staff members at PGBA,Tri-Atlantic, TMA, and Lead Agent TRICARE Mid-Atlantic Region 2.

At the onset of the case study TRICARE Mid-Atlantic Region 2 was receiving complaints from network providers that non-institutional professional claims where not processed within contracted standards and that delays in payment were occurring. Network providers were threatening to leave unless immediate action occurred. Reports generated by the MCSC illustrated that the percentage of retained claims processed by the FI were in compliance with contracted standards. By September 2000, improvements were already implemented or in progress to address the need for process simplification, improved timeliness of claims processing and increased electronic claims submission and auto-adjudication (TMA, 2000). TMA initiated Work Simplification contract modifications, a comprehensive expert review of the claims process, and partnering with the MCSC.

However, the Lead Agent and the MTF Commanders still lack sophisticated management decision-making tools that are responsive to the end-user. They are unable to customize reports and accurately pinpoint problem areas in claims processing which impedes their ability to validate network provider allegations of non-compliance. This case study uses the ARS Bridge to validate the provider's allegations that delays in claims processing were occurring prior to adjudication of the claim.

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CHAPTER 1

INTRODUCTION

Background

Managed care organizations (MCO) must make every effort to improve the effectiveness of claims processing and reporting or they will risk the loss of member and provider satisfaction and ultimately lose their ability to remain solvent. The status of claims administration has been elevated in light of the fact that somewhere between 73 and 93 percent of all premium dollars are paid out for medical care in capitation and claims payments. An effective MCO will use claims processing data to manage the cost of health care on a case basis and in aggregate. Designing appropriate claims reports is essential to a well-managed healthcare organization's ability to effectively forecast liability trends and institute corrective steps.

Under the Government's managed care plan TRICARE, the Managed Care Support Contractor (MCSC), is at risk for the delivery of health care services to Department of Defense (DOD) beneficiaries as well as the expenditure of health care dollars to each adjudicated claim. TRICARE has had claims processing timeliness and accuracy issues since its inception due in large part to the numerous eligibility categories, differing cost shares and benefits, the three health plan options (Prime, Extra, and Standard), and its reliance on data exchanges. TRICARE Management Activity (TMA) recognized that failure to respond immediately to beneficiary and provider concerns regarding claims processing would result in the loss of both patients and network providers. In August 1999, the Government Accounting Office proposed the adoption of strict timeliness and accuracy standards and embracing Medicare's system of interest penalties. The proposal focused on tightening the timeliness standard of 75% of claims processed within 21

days and facilitating electronic filing. Current, TRICARE contracts require the MCSC to process 95 percent of clean claims within 30 days and 100 percent in 60 days. An interest charge is levied against the MCSC for any clean claims not processed within 30 days from receipt. A clean claim is one that does not require the claim processor to investigate or develop information external to their operation (GAO, 1999).

Ensuring the success of the MCSC and the TRICARE claims process is a formidable and necessary task for the Military Health System (MHS). The claims process is an integral part of any managed care organization as claims data is used to project costs and utilization enabling the MCO to set prices and gain market share (Kongstvedt, 1997). When claims decisions are delayed and payments are inaccurate, member and network provider satisfaction is adversely affected and TRICARE's ability to ensure that beneficiaries have adequate access to healthcare is severely diminished (Quinn, 1997).

Historically, CHAMPUS claims processing was accomplished via a direct contractual relationship with Fiscal Intermediaries (FI) and the Government. With the advent of TRICARE Managed Care Support Contracts, claims processing responsibilities fell to the contractor as either a prime contractor or subcontractor function (See Appendix A for a graphic of Regions by Contract and Claims Processors). In TRICARE Mid-Atlantic Region 2, the FI is Palmetto Government Benefits Administrators (PGBA) who under the direction of the Managed Care Support Contractor, Anthem Alliance Health Insurance Company is responsible for TRICARE claims preparation, adjudication, and payment (See Appendix A for a graphic of the FI's area of responsibility in Region 2). TRICARE claims adjudication is complex and is the end product of eligibility, enrollment, authorizations, benefit design, and network development. PGBA's productivity and efficiency is dependent on the interface with the Defense Enrollment Eligibility Reporting System (DEERS), the Composite Health Care System (CHCS), TMA, and individual

provider office products. Proper claims adjudication relies on accurate eligibility and enrollment data files, document preparation, imaging, indexing, and hand keying as well as the timely communication of benefit design changes and implementation of new products. The TRICARE enrollment process involves the interface of numerous systems, which complicates and slows down the process (See Appendix B for a model of the process). The DOD recognized that preemptive strategies and tactics were necessary to ensure the success of the claims process. A three-step approach for improving claims processing was adopted and is referred to as Claims Processing Work Simplification Initiatives, expert consultant review, and partnering with their MCSC.

Claims data must be used to generate reports that facilitate effective health care management and forecasting decisions (Kongstavdt, 1996). Health care executives at all levels of the Department of Defense from the Office Assistant Secretary Defense for Health Affairs, to regional Lead Agents, and Commanding Officers of military treatment facilities need to analyze real-time data to ensure beneficiaries have access to quality cost effective health services. In 1996, the DOD initiated the migration of data elements from the Source Data Collection System (SDCS) to the Corporate Executive Information System (CEIS) populating the executive decision-making applications QUANTUM, TRENDPATH, and TRENDSTAR.

SDCS collects and edits the purchased care cost, workload and contractual data necessary to administer a major health benefits program for entitled beneficiaries through TRICARE Managed Care Support Contracts and ensure their financial accountability. All data collected by SDCS is made available to each Lead Agent, MTF and other users, within 24 hours after collection via the on-line system for accessing and retrieving CHAMPUS health care data, the Care Detail Information System (CDIS). CDIS is a near real-time system that uses the data

collected by the Source Data Collection System to create subject area summary databases (TRICARE Factsheet, 1997).

Unfortunately for the DOD, users of CEIS found the reports generated by the system to be unreliable and inaccurate. Extracting data from multiple sources without flow-charting how the data was derived further frustrated the users. The Data Dictionary was vague and of poor quality and the help-line did not direct questions to data element experts The canned reports in QUANTUM were out dated, ineffective and non-specific for making day-to-day decisions. TRENDSTAR ad hoc reports were difficult to write due to the lack of technical support and value-added supplements to make the user self-sufficient. Dissatisfaction with CEIS applications QUANTUM, TRENDPATH and TRENDSTAR lead the DOD to decide to end the contract after December 2000 (TMA, 2000).

Currently, the DOD is reviewing the All Region Server (ARS) Bridge, a product created to provide ad hoc user access to MHS data extracted from multiple source data collection systems. Data from multiple sources such as CHCS, ADS, DEERS, National Mail Order Pharmacy, MEQS, TMA (West) and the Medicare Processing Center have been brought together in a single system to facilitate analysis of the MHS operations (Science Applications International Corporation, All Region Server Bridge User's Guide Supplement, 2000). Data from TRICARE (West) will contain the Health Care Service Record.

Problem Statement

The reports generated by the MCSC regarding the status of claim processing are ineffective and inefficient for making day-to-day management decisions that affect network provider satisfaction with TRICARE payment timeliness and accuracy. In order to reduce health care costs, Lead Agents and Commanding Officers of military treatment facilities must proactively identify, quantify, and communicate the sources of variation in claims processing in

order to take corrective actions. Currently, individual claims problems are only addressed, explained, and/or corrected when an issue is raised. The Managed Care Support Contractor is required to submit to the Contractor Evaluation Office, TRICARE-Aurora Monthly Workload Reports of combined network, non-network and Medicare BRAC data for each state in its jurisdiction. The "TRICARE Region's 2/5 % Combined Claims Processing Performance Report" measures the percentage of retained claims processed to completion within 30 days capturing only the amount of time it took from receipt to process completion but not "why a claim was paid, denied, or delayed." A claim is defined as any request for payment for services rendered related to care and treatment of a disease or injury which is received from a claimant by a TMA contractor (TRICARE Operation Manual, Part One, Chapter 3, 2000). A processed claim indicates that a claim will either be paid or is denied and that all claim processor actions have been fulfilled. By rolling both results, paid or denied, into one measure the true impact of claims processing on provider satisfaction with TRICARE claims timeliness and accuracy is lost, and as depicted in Appendix C, the process appears to be in statistical control. In TRICARE Mid-Atlantic Region 2, health care providers are alleging that TRICARE is slow in paying claims and that keying errors have a significant financial impact on their practices. The potential loss of network providers threatens the ability of TRICARE to guarantee access to quality health care to its beneficiaries. TMA has reviewed proposals to modify MCSCs to generate detailed reports that would in effect follow a claim from acceptance into the custody of the FI to payment or denial but concluded it was cost prohibitive (TMA, 2000). The DOD must seek out a cost-effective data extraction system that will provide ad hoc access to users while at the same time isolate the claims process from workload data. This will allow users to pull data elements from multiple sources, understand where the data elements are derived from, and independently use a data dictionary to develop meaningful reports.

Literature Review

Managed Care has forever changed the landscape of health care delivery in the United States effecting quality, access, and cost. Those who directly pay for health care, the government, businesses, and insurers have spurred on this change necessitated by their need to reduce the escalating costs of providing medical care to beneficiaries and employees (McCullough, 1999; Larkin, 1999). Health care is a one trillion-dollar industry whose expenditures presently comprise over 14 percent of the domestic gross national product (Proctor, 2000; Larkin, 1999).

In an effort to improve access to medical care while keeping escalating medical costs in control the government turned to managed care. From 1988-1993, the CHAMPUS Reform Initiative (CRI) in California and Hawaii offered DOD beneficiaries a choice of ways in which they might use their military medical care benefits. After five years of successfully slowing costs and achieving overwhelming patient satisfaction with the CRI demonstration, the DOD decided to extend the program nationwide (TRICARE Factsheet, 1999). A new program emerged called TRICARE with a triple option structure (See Appendix D for a description of the TRICARE triple option and TRICARE Benefits and Coverage Charts).

The procurement and oversight of TRICARE Managed Care Support contracts is provided through the Office of the Assistant Secretary of Defense for Health Affairs, TMA and regional Lead Agents. The Lead Agents are responsible for oversight of the health care requirements of the contracts. Each Lead Agent participates directly in the contract operations through a program manager and an administrative contracting officer assigned to the Lead Agent's staff. Health Affairs is responsible for the business process requirements of the contract such as claims processing and data collection; however, Lead Agents have the opportunity to review claims processing rules and propose changes to Health Affairs (TRICARE Policy

Guidelines, 1998). In August 1999, the Government Accounting Office reported to Congress that TRICARE needed to improve claims processing timeliness and accuracy in order to attract the number of civilian providers necessary to ensure that beneficiaries have adequate access to healthcare (GAO, 1999).

Claims administration is an integral part of any MCO, claims data is used to project costs and utilization enabling the MCO to set prices and gain market share. When claims decisions are delayed and payments are inaccurate, both customer satisfaction and the MCO' ability to compete are adversely effected. The viability of the MCO, its ability to manage its assets and liabilities, is influenced by the claims administration department's effective management of claims and referrals (Konstvedt, 1996). In the Government's managed care system TRICARE, the function of claims processing is subcontracted to a Fiscal Intermediary (FI). In a majority of the TRICARE Regions, Palmetto Government Benefit Administrators, a subsidiary of Blue Cross/Blue Shield is the responsible FI (See Appendix A for a graphic of the Regions by Contractor and Claims Processor). The financial risk of providing healthcare to the Department of Defense beneficiary population and management of premium dollars falls to the MCSC and its FI.

Claims administration is an integrative and interdependent function. Its productivity and efficiency is dependent on numerous divisions of the organization, such as, sales, benefit coverage, enrollment, authorization and management information systems. "The first step in ensuring the success of the claims administration process is to define clearly and agree on its purpose both within the department and between the department" (Eichler & McElfatrick, p. 492). Claims administration fulfills the following five basic purposes: plan contract administration, benefits administration, medical management policy administration, member and provider service, and liability protection.

The first major purpose of claims administration is to provide plan contract administration ensuring that the MCO meets contractual obligations that it has made with employer groups, members, and providers. Claims related contractual obligations include benefits, processing time frames, reimbursement methodologies and amounts, appeal mechanisms, and grievance procedures (Kongstvedt, 1997). Historically, CHAMPUS claims processing was accomplished via a direct contractual relationship with Fiscal Intermediaries and the Government. When TRICARE Managed Care Support Contracts were brought on-line there was no longer a direct contractual relationship between the FI and the government. Consequently, the DOD was no longer at risk for either the expenditure of healthcare dollars or the adjudication of claims. Unfortunately, TMA continued to monitor the MCSC as if the government maintained the risk and was overly prescriptive with literally thousands of edits that slowed the claim process down. It is recommended by Kongstvedt (1996), that the claims administration supervisor or in the case of the government, the MCSC and its FI, establish appropriate workflow and control mechanisms as well as coordinate efforts throughout the MCO to ensure timely and appropriate processing of claims, appeals, and grievances. In September and October 1998, TMA invited the Chief Executive Officers from each of the seven Managed Care Support Contracts to conduct a comprehensive review of all current contract provisions to identify those that could be modified or eliminated with no up-front costs to the Government and would result in cost savings for the MCSC. The result was a list of recommendations that, when implemented, would simplify the claims process.

The goal of the Work Simplification Initiatives was to optimize claims processing by modifying current contracts to eliminate unnecessary or duplicative processes emphasizing the use of commercial best practices and the use of Medicare procedures where possible.

The following initiatives have been implemented: simplified the provider authorization process (Summer 1999), eliminated prescriptive controlled development (Summer 1999); increased the claims processing cycle time standard (Fall 1999); allowed commercial best practices for utilization management (Fall 1999, full-implementation year-end 2000); and increased the transition time between award of the contract and start work date to a minimum of nine months which was implemented in 1999. Changing the third-party liability collection approach has been delayed pending resolution of cost issues and is not expected until year-end 2001 (TMA, 2000).

The first recommendation was to adopt the commercial best business practice of returning incomplete claims or "uncontrolled" with a request for additional information without tracking in the claims inventory, thereby eliminating prescriptive controlled development requirements. Prior to the summer of 1999, DOD had required contractors to use controlled development processes whenever a claim was received without all the information necessary to allow processing. Contractors would have to track claims and continue to count days against the 21-day standard while requesting the required information from the beneficiary or provider. Contractors would age the claims for a maximum of 35 days, if the additional information requested was not received within the 35 days the claim was denied. Eliminating controlled development removed the administrative burden from the contractor of having to track requests for additional information and allowed them to use their time constructively; adjudicating claims that could be processed. The contractor would continue to call or write providers and beneficiaries requesting additional information the only difference would be that the contractor would not be required to track the requests and claims would not be automatically denied on the 35th day (TMA, 1999).

Another recommendation adopted in the summer of 1999 was the discontinuation of provider authorization, the process by which the provider's licensure, education and experience

is verified by the MCSC. Provider authorization required that no claims payments be made to a provider until the validation was complete. Revalidation occurred at the beginning of each new contract and again every two years. Upon review the DOD determined that the practice of revalidation did not add value because once obtained, the minimum provider education and experience (required for authorization) would not be removed. The validation only served to ensure that a provider maintained licensure, which is a state responsibility. Recognizing that provider authorization was a duplicative effort, the DOD discontinued the practice of revalidation of licensure (TMA, 1999).

A major purpose of claims administration is to ensure that the medical management policy is adhered to. The policy states that covered services must be medically necessary and appropriate. Medical necessity and appropriateness is a concept that is administered on a claim, or case specific, basis given individual clinical circumstances (Kongstvedt, 1997). Claims administrators must be mindful of the medical management policy when considering the types and services requiring preauthorization and when to refer cases for clinical review. The medical director, in conjunction with his/her medical management staff, establishes, contractually, the types of services and procedures that require prior approval. Referral authorizations and precertifications serve as instructions to the claims administrator on how to handle subsequent claims. It is essential to avoid unnecessary and costly medical review. Claims administration must coordinate with the medical management staff to define those types of cases that must receive clinical review for coverage determination and those claims that can be processed by the claims staff with specific guidelines (Kongstvedt, 1997). In the fall of 1999, DOD initiated efforts to gradually stop the practice of unnecessarily prescriptive utilization management and claims review requirements. A practice that resulted in thousands of “edits” in the automated claims processing system used by PGBA resulting in needless deferral of claims to medical

review (TMA, 1999). DOD recognized that the MCSC was at risk for correctly managing premium dollars and not the government. Therefore, it was the contractor's responsibility to determine what medical review edits must be in place to guard against the unnecessary expenditure of health care dollars while meeting the fiscal obligations of each legitimate claim.

Another modification to the MCSCS was the change in claims processing cycle times that occurred as a result of the Work Simplification Initiatives and the 1999 GAO report on the monitoring of claims processing activities. The GAO report noted that TRICARE contractors in 8 of the 11 regions processed 86 percent (or 16 million) of the claims on time, exceeding DOD's timeliness standard of processing 75 percent of claims within 21 days; however, only 66 percent of hospital or institutional claims were processed on time, and 81 percent of professional claims were processed on time. In addition, the nearly 3 million claims that did not meet the timeliness standards were mostly from physicians and other providers (GAO, 1999). Modifications to MCSCS took place in the fall of 1999 requiring the contractor to process 95 percent of clean claims within 30 days and 100 percent within 60 days. Additionally, the MCSC is now subject to an interest payment on any clean claim not processed within 30 days. As stated previously, a clean claim is one that does not require a claim processor to investigate or develop information external to their operation (TRICARE Operations Manual, 2000, TMA, 1999 & GAO, 1999). When managed care organizations enter into contractual agreements with employer groups, customers, and providers they are liable to provide defined benefit coverage, in a specified time frame, and for a specified reimbursement rate. "All claims processing errors, whether they result in overpayment or underpayment, present additional and unnecessary liability for the organization" (Eichler & McElfatrick, 1996, p. 493).

Claims administration is responsible for the coordination of the member and provider service and to resolve conflicts that arise out of claims processing errors or late payments. It is

incumbent upon claims administration to have effective communication and problem solving abilities in order to effectively interact with customers and providers (Eichler & McElfatrick, 1996). Under TRICARE, a beneficiary has numerous avenues from which to elicit help in understanding a bill or the Explanation of Benefits (EOB). They can contact a Beneficiary Claims Assistance Counselor (BCAC) and/or a Health Benefit Administrator at a military treatment facility, contact the Lead Agent, visit a contractor representative at a TRICARE Service Center or contact the FI on-line. To resolve claims issues in TRICARE Mid-Atlantic Region 2 a beneficiary or provider can contact PGBA at MyTRICARE.com (TMA, 2000).

MCSCS are responsible for identifying claims subject to third party liability (TPL) and for conducting a preliminary investigation of all potential third party recovery claims. The Government not the contractor retains the recovered funds. The Federal Medical Care Recovery Act (42 U.S.C.2651-2653) provides for the recovery of the costs of medical care furnished by the United States to a person suffering a disease or injury caused by the action or negligence of some third person (TMA, 1999). TPL recovery is the responsibility of the Uniformed Services Claims Officer and not the MCSC.

The identification of potential TPL claims is based on the diagnosis on the claim. Claims with a diagnosis indicating potential TPL are suspended in CRIS. This includes all inpatient claims and outpatient claims with billed charges that exceed $500 and a diagnosis code in the 800-999 range. The MCSC forwards a DD Form 2527, Personal Injury Questionnaire to the beneficiary who is given 35 days to complete and return a signed form. If the DD Form 2527 is not returned within 35 days the claim(s) is (are) denied (PGBA, 2000). The current system of TPL results in denied claims and frustrated beneficiaries. Proposed changes to the TPL system focus on when information is requested from beneficiaries and who will pursue recovery the MCSCS or Uniformed Services Claims Officers. The FY 99 Defense Authorization Act has

cleared the way for a “pay and chase” process eliminating the need to coordinate with payers other than the primary other health insurance prior to processing payment of a claim (TMA, 1999).

Kongstvedt (1996) explains that claims administration also functions as benefits administration. This function requires intricate knowledge of contractual agreements made between the MCO and employer groups, customers, and providers. The contract describes benefits for eligible members by category of care, limitations, member cost-sharing obligations, and exclusions. It is the task of the claims administration to translate benefit coverage issues found in the contract into specific CPT-4 and IDC-9 procedural codes. It is imperative that the claims processors interpret and translate each line of the contract explicitly and apply it to the claim line item level in their automated system. For example, if the benefit description includes durable medical equipment and repairs when necessary. The claims processor must describe in detail what type of wheelchair is going to be covered.

The FI is required to electronically transmit 56 data elements to TMA on a daily basis that are used to generate the Health Care Service Record (HCSR). All HCSRs submitted to TMA are processed through an editing system to validate basic data quality. The editing process applies basic industry standards, published validity, as well as relational and consistency edits to prevent data variances. If a HCSR fails the elaborate editing process it is immediately returned to the FI for correction and resubmission within the contract times allowed. According to TMA, incorrect data represents about 5% of all the elements received (TMA, 1999).

A HCSR consists of either an institutional or non-institutional record. An institutional HCSR is the submission of treatment encounter data created by the formal acceptance by a hospital or other authorized institutional provider of a beneficiary for the purpose of occupying a bed day for at least 24 hours (TRICARE ADP Manual, 2000). A non-institutional HCSR consists

of all other treatment encounter data including institutional care in connection with ambulatory surgery. Types of HCSRs include: initial submission, adjustment submission, and resubmission.

Initial submission refers to the first submission of a new HCSR; administrative reimbursement is based only upon initial types of HCSRs. Adjustment submission refers to a previously submitted and accepted HCSR, which require adjustment due to processor errors or the need to update prior data with more current and accurate information. Adjustments are never permitted on a complete contractor denial HCSR. Reopening of a previously denied HCSR must be submitted as a new initial submission HCSR. Conditions, which prompt an adjustment, include:

a. Error in information received from the provider or beneficiary
b. Late submission of data from providers
c. Error in processing by current or prior contractor
d. Deductible corrections
e. Successful recoupment of monies, or receipts of a refund from the provider, beneficiary, or third party
f. State dated payment checks

Adjustment submissions are considered positive when additional monies are being paid by the contractor, negative when monies are being credited back to the contractor, or statistical when serving to correct prior information but have no impact on the payment amount (TRICARE ADP Manual, 1999). Resubmission applies to initial and adjustment HCSRs that have failed to pass the TMA editing system. All failed records are rejected and returned to the FI for correction and resubmission. No administrative reimbursements will be made until all initial HCSRs making up a claim pass the TMA edit system (TRICARE ADP Manual, 1999).

As part of the Work Simplification Initiatives, TRICARE is re-evaluating the HCSR to determine its suitability for meeting the DOD managed care data requirements as well as the requirements of the National Health Care Accountability and Portability Act (TMA, 1999).

Managed care organizations must deliberately position claims administration in such a way that it can establish and maintain effective relationships with its corporate colleagues. It is management's responsibility to ensure that the necessary integrated policies, procedures, information, and workflow exist to enable claims processing to run effectively (Kongstvedt, 1997). Management's inability to optimize the functions of claims administration will undermine the financial effectiveness of a MCO and severely limit its ability to accurately set capitation and premium rates.

Proper positioning within the organization will allow claims administration to exploit unique opportunities that can enhance the effectiveness and efficiency of the entire organization. A strong claims administration department, which is appropriately positioned within the organization and has adequate resources, has the opportunity to positively influence customer and provider satisfaction. Additionally, the opportunity exists to develop constructive working relationships with virtually every facet of the organization encouraging problem identification across numerous departments. The ability to interpret and clarify contracts for providers and customers offer yet another unique opportunity for the claims administration department to observe and bring to management's attention inconsistencies between documents and/or loopholes (Eichler & McElfatrick, 1996).

Claims administration has the opportunity through the creation and maintenance of an effective medical database to enhance the organization's ability to use claims data to improve the health of the served population. The claims and encounter data can be used for quality assurance and quality improvement studies. The National Committee for Quality Assurance (NCQA), the

accrediting body for Managed Care Organizations, suggests that health maintenance organizations (HMO) have databases that facilitate meeting the Healthy People 2000 targets. The targets seek to increase the years of health life for Americans, reduce health disparities and achieve access to preventive services for all Americans. NCQA recommends the use of claims data to comply with their preventable illness standards and show evidence of the quality of care provided. For example, Blue Choice, an individual practice association model HMO with more than 350,000 members, has set up a three-phase study to improve immunization compliance rates. The first phase of the study involved establishing baseline compliance figures using paid claims and membership data. The baseline measles, mumps, and rubella (MMR) vaccination rate yielded a 91.7 compliance rate. The second and third phase involved retrospective record reviews as well as follow-up telephone calls to non-compliant members to determine the impact of intervention on MMR vaccination rate (Cleary, 1995). It is clear that the use of claims data in combination with the medical record and administrative data can show evidence that a MCO has improved the health care status of its served population. MCOs that wish to remain viable and gain market share must use claims data to distinguish its product line from that of its competitors. Another way to demonstrate the quality of an organization is to use the Health Plan Employer Data and Information Set to compare health plan performance (Cleary, 1995). The use of claims data to gain market share and accurately reflect the quality of services provided is vital to the organization's financial success.

Claims administration can be functionally placed in many areas to include financial, operational, or management information systems (MIS) realm. Strong arguments can be made for placing claims administration under the control of either finance or management information systems. Claims processing is a complex accounts payable function that is heavily reliant on MIS to define, store, and process claims. However, most organizations elect to position claims

administration under the control of operations. Additionally, it is more advantageous if claims administration reports to a director or vice-president who is on par with the director of finance, operations, and MIS giving claims administration the power and importance it needs to function effectively within the MCO (Eichler & McElfatrick, 1996).

Claims administration is responsible for controlling its inventory, its claims and its encounters. “In a MCO, cash obtained through premium revenue is the primary source of assets; capitation and claims expense are the primary sources of liabilities” (Eichler & McElfatrick, 1996, 499). An effective claims administration department will define its inventory, determine an acceptable level, evaluate current inventory and develop a system to control and report on it. It is essential that all claims and transactions are identified by type and processing stage. Examples of types of claims are electronic receipts, paper claims/encounters, suspended or pended transactions, authorizations and referrals. Claims should be categorized by processing stage, for example: in preparation, received but untouched, received and processed, why suspended, suspense age, and when resolved. Effective inventory control allows for the accurate tracking and management of the largest category of aged claims against the MCO, the pended/suspended claims (Eichler & McElfatrick, 1996).

In November 1999, the consultant comprehensive evaluation and assessment of DOD claims processing was completed and recommended changes to the process have been implemented throughout 2000. The proposed changes are expected to improve beneficiary and provider satisfaction through improved claims processing timeliness and reduction of deferrals or denial of claims. The consultant review recommended the increase in electronic claims submission and auto-adjudication; improve customer service targeting provider and beneficiary education; enhance management reporting capabilities and program wide data quality; improve

enrollment and eligibility processing and enhance fraud and abuse migration capabilities (TMA, 2000).

Purpose

The intent of this study is to analyze and evaluate ad hoc reports created with the All Region Server (ARS) Bridge accessing data from the Health Care Service Record to ascertain if they can be used to indicate whether payments of non-institutional professional claims are delayed beyond the contractual established timeliness standard. The contractual provision requires MCSCs to process 95% of all claims within 30 days and 100% within 60 days. It is incumbent upon the Lead Agent and MTF Commander to ensure that network providers are satisfied with the timeliness and accuracy of TRICARE claims processing or risk unacceptable levels of network provider turnover. The findings will be used to provide recommendations for system improvements to the Lead Agent and MTF Commanders.

CHAPTER 2

METHODS AND PROCEDURES

The research method selected for this project is a case study. According to Sypher (1990), and Yin (1989), it is the appropriate research form when seeking answers to "why" or "how" questions when the investigator has little or no control over the process being analyzed. This study will use a variety of informational sources allowing for data to be verified and not overlooked. The case study method emphasizes detail that provides valuable insight into problem solving, evaluation, and strategy development (Cooper & Schindler, 1997). The method selected seeks to evaluate non-institutional professional claims processing timeliness and accuracy in TRICARE Mid-Atlantic Region 2 using the All Region Server (ARS) Bridge. The ARS Bridge is a decision support tool that enables the user to access data via a query and create reports from an organization's database(s) referred to as its universe. The ARS Bridge tool is designed to provide end-users with a means to analyze data from different viewpoints and on different levels of detail (BusinessObjects Users's Guide, 1998).

TRICARE Mid-Atlantic Region 2 non-institutional network providers are threatening to leave the network due to inaccurate and untimely claims processing. Should providers follow through on this threat, it is believed that the quality of care provided to our beneficiaries could be jeopardized. It is imperative that Lead Agents and MTF Commanders have the ability to create detailed reports necessary to correct inefficiency and ineffectiveness in claims processing. Current status reports do not reflect a significant delay in payment to providers beyond the contracted standards (See Appendix C which details that greater than 95% of retained claims are process within 30 days of receipt of the claim). As such these reports do not provide decision-makers with the information necessary to address and identify claims processing issues.

The potential advantage of a case study is the emphasis on detail which provides valuable insight for problem solving, evaluation of information that may lead to hypotheses formulation, clarification of concepts and variables for further study (Cooper & Schindler, 1998). The primary disadvantage of a case study is the inability to generalize findings to a larger population based on the narrow focus. However, this is not considered a limitation in this study as improvements in the TRICARE claims process may be more difficult to implement and maintain in certain regions compared to others depending on the generation of the TRICARE contract, contract specifications and the assimilation of managed care principles.

This case study was conducted through review and analysis of the Managed Care Support Contract in TRICARE Mid-Atlantic Region 2, TMA Policy Guidelines, TMA Operations Manual, TMA ADP Manual, BusinessObjects User's Guide, memoranda, interviews, contractor site-visits and published literature. In addition, data was gathered through structured and unstructured interviews with staff members at PGBA,Tri-Atlantic, TMA, and Lead Agent TRICARE Mid-Atlantic Region 2 and through participation in CRIS training. According to Yin (1989), an unsequenced case study allows the researcher to describe dynamic organizational structures.

Documents were reviewed and analyzed to describe the Claims Processing Work Simplification Initiatives that have been implemented by TMA and those being considered and to ascertain if the ARS Bridge could query the HCSR database and generate detailed reports enabling Lead Agents and MTF Commanders to determine if non-institutional professional claims where processed within contracted standards or if delays in payment were occurring.

There are three major criteria for evaluating research design quality: validity, reliability, and practicality (Cooper & Schindler, 1997). Validity refers to the extent to which a test measures what we are actually measuring. It involves gathering empirical evidence to support the inference

that the measure chosen has meaning. The study will use a variety of information sources to reduce measurement error, unfounded inferences, and to increase generalization of the findings beyond the immediate study.

Reliability refers to the accuracy and precision of a measurement procedure. The goal of reliability is to minimize errors and bias in a study and to allow replication of the study to yield consistent results (Cooper & Schindler, 1997). Reliability is a precursor to validity. In this study, it is important that the researcher determine if the data elements transmitted from PGBA have the same meaning and relationship in the HCSR as they do in the ARS Bridge.

According to Cooper and Schindler (1997), the scientific requirements for any project involve practicality. There is always a trade-off between the ideal project and the budget. In this case study cost constraints are not a limiting factor. Another aspect of practicality involves convenience. The instrument of measure chosen in this case study is the ARS Bridge, which is being field tested by the Lead Agent Mid-Atlantic Region 2.

Data was obtained using the ARS Bridge to determine the percentage of initial HCSR submissions and the resubmission rate for Region 2 for all Network Non-Institutional Claims processed in FY 1999 and FY 2000. The Network FY 1999 Non-Institutional data covers from October 1998 through October 1999 as reported on January 2001 and made available in the ARS Bridge in February 2001. The Network FY 2000 data covers October 1999 through September 2000 as reported on January 2001 and made available in the ARS Bridge in February 2001 (Appendix E contains the ARS Bridge Data Dictionary and Appendix F graphically illustrates how the ARS Bridge query was built and provides a summary). Data was then obtained from the ARS Bridge to determine the percentage of initial HCSR submissions and the resubmission rate for a particular radiology group in Region 2 for FY 1999 and 2000 (See Appendix F).

CHAPTER 3

EXPECTED FINDINGS AND UTILITY OF RESULTS

At the onset of the case study TRICARE Mid-Atlantic Region 2 was receiving complaints from network providers that non-institutional professional claims where not processed within contracted standards and that delays in payment were occurring. Network providers were threatening to leave unless immediate action occurred. Reports generated by the MCSC illustrated that the percentage of retained claims processed by the FI were in compliance with contracted standards (See Appendix B, TRICARE Claims Processing Performance for all regions and for region 2/5). By September 2000, improvements were already implemented or in progress to address the need for process simplification, improved timeliness of claims processing and increased electronic claims submission and auto-adjudication (TMA, 2000). TMA initiated Work Simplification contract modifications, a comprehensive expert review of the claims process, and partnering with the MCSC to initiate improvements and investigation of e-commerce options.

However, the Lead Agent and the MTF Commanders still lack sophisticated management decision-making tools that are responsive to the end-user. They are unable to customize reports and accurately pinpoint problem areas in claims processing which impedes their ability to validate network provider allegations of non-compliance.

A goal of this case study is to provide constructive input on the uses of the ARS Bridge that is currently being field-tested prior to DOD-wide implementation. If the ARS Bridge can effectively be used to evaluate claims processing than TMA, the Lead Agent, and MTF Commanders will be able to verify the MCSC's reported productivity and proactively address problems. Additionally, this case study is expected to show that utilizing the ARS Bridge to query HCSR data elements can be enhanced if data relating to claims were isolated from the entire universe of elements utilized by the ARS Bridge, thereby increasing the speed of queries.

CHAPTER 4

DISCUSSION

The initial involvement of the researcher was to determine if the Work Simplification efforts implemented or in progress to address the improved timeliness of claims processing and increased electronic claims submissions eliminated unnecessary or duplicative processes that interfered with optimal performance in claims processing. This was accomplished through extensive review of the TRICARE/CHAMPUS Policy Manual 6010.47-M (POL), June 1999, TRICARE/CHAMPUS Automated Data Processing Manual 6010.50-M (ADP), May 1999, Total Managed Care System Training Manual, February 2000 and Government Accounting Reports related to claims processing.

Following a thorough review of each instruction, report or manual and the individuals responsible for claims processing re-engineering at TMA were contacted to establish the current status the re-engineering initiatives. Using their input and input from site visits with subject matter experts at Anthem Alliance Regional Office in Hampton, Virginia and at Palmetto Government Benefit Administrators in Portsmouth, Virginia, and Camden/Florence, South Carolina, a thorough review of claims processing was conducted.

In addition, interrelationships of processes were explored resulting in a review of the enrollment process specific to Region 2 and TRICARE's Triple Medical Options (Appendix B, Graphically Depicts TRICARE Mid-Atlantic Region 2 Catchment Area and Appendix D, Details the Complexity of TRICARE' Triple Medical Option). Enrollment flow charts were generated and discussed with the responsible parties to ensure that they accurately illustrate the actual enrollment process to the Tidewater CHCS platform and its effect on claims processing accuracy and timeliness (Appendix B Shows an Overly Complex Enrollment Process).

Monthly Claim Status Reports generated by the MCSC, Anthem Alliance as required by the TRICARE Mid-Atlantic Region 2/5 contract were examined (Appendix C shows that the FI, PGBA is meeting the Claims Processing Standard of 95% of Retained Claims Processed within 30 days).

An extensive review of the TRICARE/CHAMPUS Automated Data Processing Manual 6010.50-M (ADP), May 1999 provided an insight into the development of a Health Care Service Record that consisted of either institutional or non-institutional treatment encounter data. HCSRs are submitted by the MCSC according to contracted standards and processed against TMA' editing system. All failed records are rejected and returned to the MCSC for correction and resubmission. The HCSR is used as a tool to run relational edits and validity data checks against the claims data but not as a method of monitoring contractor claims processing performance.

The All Regional Server Bridge a product designed by Science Applications International Corporation (SAIC) for Executive Information/Decision Support is currently being field tested by DOD to provide ad hoc user access to MHS data extracted from multiple source data collection systems such as CHCS, ADS, DEERS, NMOP, MEQS, TMA (West) and the Medicare Processing Center (ARS Bridge User's Guide Supplement, 2000). The TMA (West) database contains the HCSR and the ARS Bridge will allow end users to query the HCSR and produce customize reports. This researcher decided to use the ARS Bridge to query the HCSR database and proactively substantiate or disavow allegations of improper and untimely claims processing in TRICARE Mid-Atlantic Region 2. Consideration was given to the fact that the scope of the reports would be limited to the data elements used to generate a HCSR as proscribed by TMA (TMA, 2000). It is expected that the ARS Bridge will show that delays in

claims processing are occurring, but that it will be unable to identify who is responsible for the errors, the provider, the processor or the claim processing logic.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

The data showed that the percentage of initial HCSR submissions for Network Non-Institutional Claims in Region 2 for FY 1999 was 83.03% and for FY 2000 was 85.12% and resubmission HCSR rates were 12.02% and 11.80% respectfully. For Region 2, approximately 84% of Network Non-Institutional Claims were passing through TMAs editing system while 11% of Network Non-Institutional Claims were being returned to the FI for correction and resubmission. No administrative reimbursements will be made until all HCSRs making up a claim pass the TMA editing system (TMA, 2000). The ARS Bridge generated data that showed delays in processing were occurring for all Network Non-Institutional Claims in Region 2 prior to the beginning of the adjudication process.

In order to validate Region 2 network providers allegations that claims processing was untimely, data was obtained on a Region 2 radiology group using the ARS Bridge (See Appendix G and H for a Summary of All Claims for a Network Radiology Group for FY 99 and FY 2000). The results showed that the percentage of initial HCSR submissions for the radiology group for FY 1999 was 89.25% and for FY 2000 was 90.57% and resubmission HCSR rates were 9.49% and 8.66% respectfully. For the radiology group, approximately 90% of their claims were passing through TMAs editing system while 8.66% of their claims were being returned to the FI for correction and resubmission. The ARS Bridge validated the radiology group's allegations that the TRICARE claims process was untimely since delays were occurring prior to the FI adjudication (See Appendix I for a Summary Comparison of All Claims Region 2 for FY 99 and FY 00 Compared with a Particular Radiology Group).

TRICARE claims processing is complex and unique in the health care industry due to factors as numerous eligibility categories; different cost-shares, deductibles and benefits for three

distinct programs (Prime, Extra, and Standard). The ARS Bridge is a valuable tool for the health care administrator to effectively identify, quantify, and communicate sources of variation in their business practices and to improve their decision-making capability. Identification of barriers and obstacles to the claims process is a formidable task, but with the use of the ARS Bridge, the task maybe more manageable. As part of the claims processing improvement plan TMA is re-evaluating the HCSR to determine its suitability for meeting the Military Health Systems' managed care data requirements (TMA, 2000). Understanding the claims process and overcoming obstacles to claims processing timeliness and accuracy is key to the overall success of TRICARE. The Work Simplification Initiatives already underway along with the decision-making tool, the ARS Bridge will assist MTF Commanders and Lead Agents in making sound decisions that may prevent unnecessary departure of quality providers from their networks.

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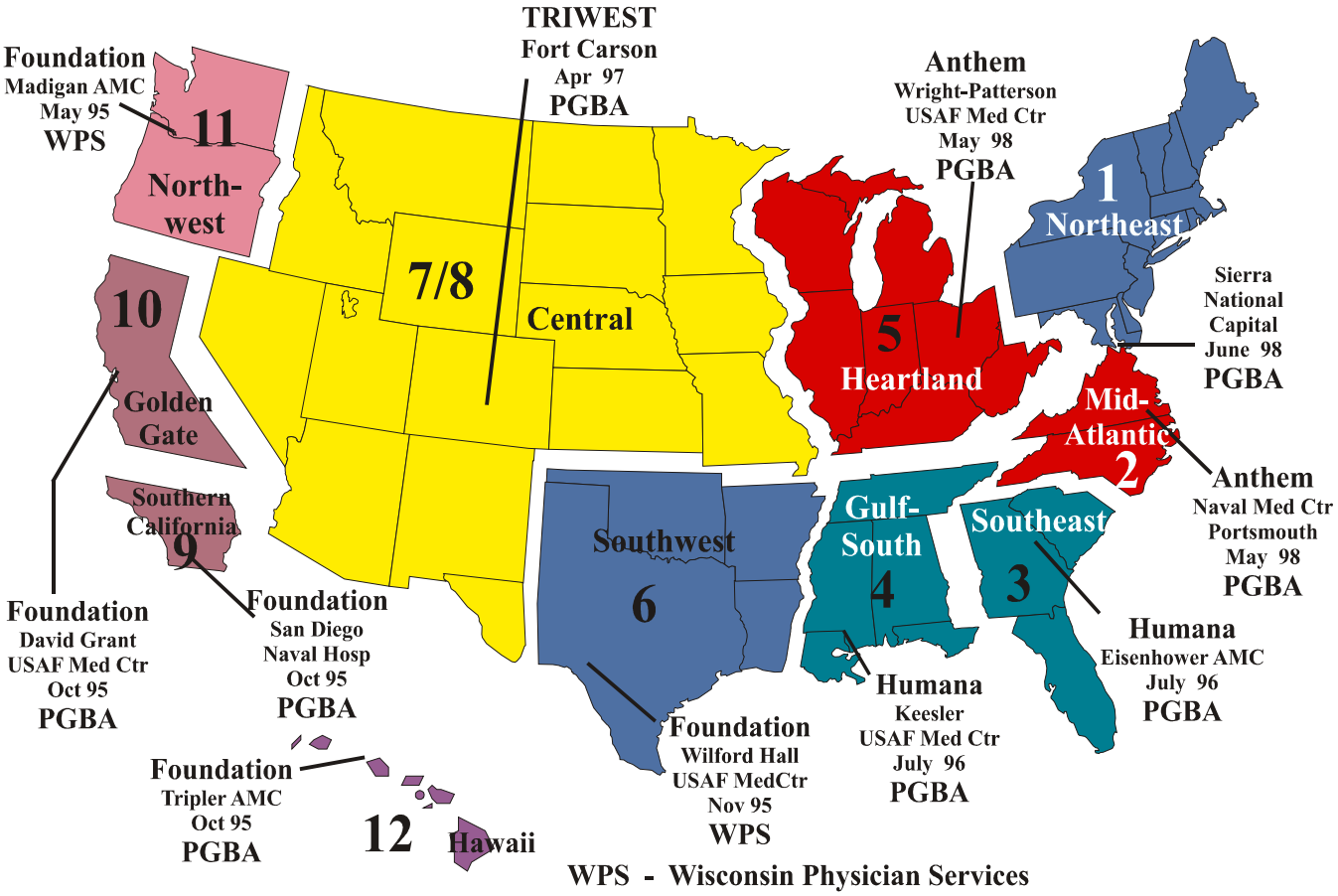
APPENDIX A

TRICARE REGIONS BY CONTRACTS AND CLAIMS PROCESSORS (SUBCONTRACTORS)

TRICARE MID-ATLANTIC REGION 2 AREA OF FISCAL RESPONSI BILITY

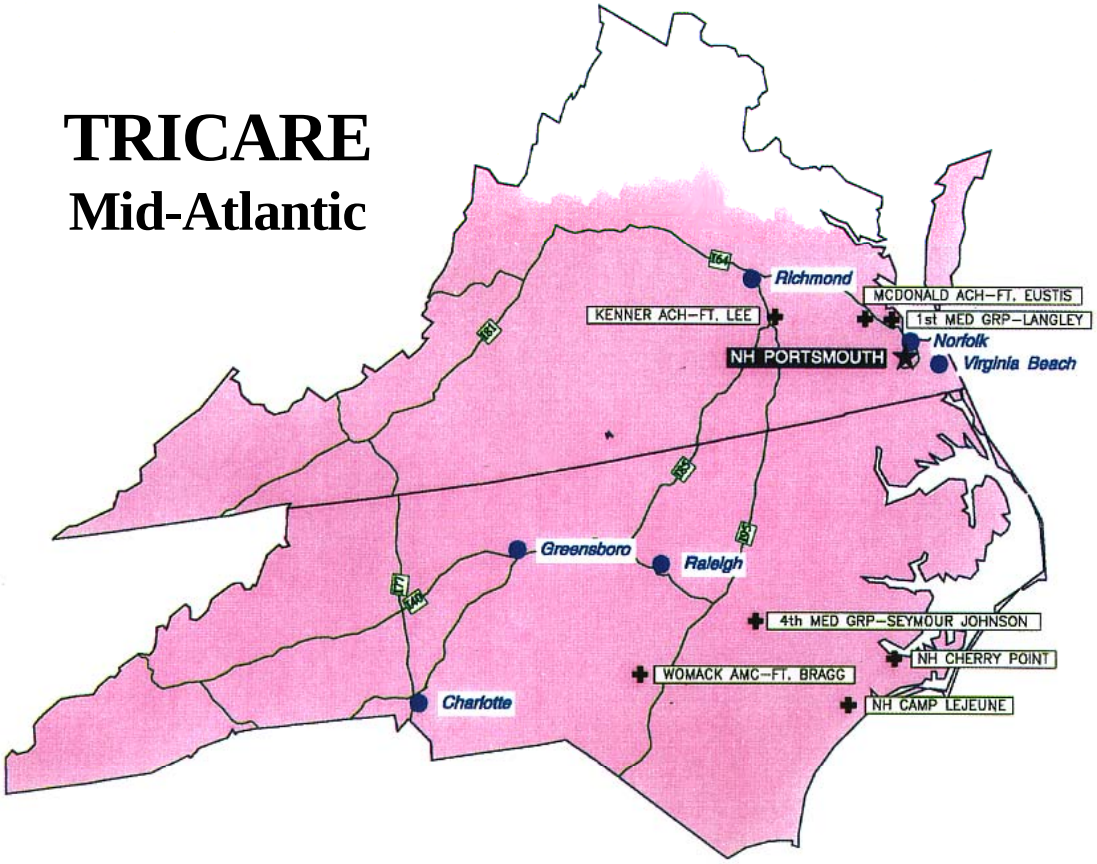
TRICARE

Regions by Contracts and Claims Processors (Subcontractors)



WPS - Wisconsin Physician Services
PGBA - Palmetto Government Benefit Administrators

TRICARE
Mid-Atlantic



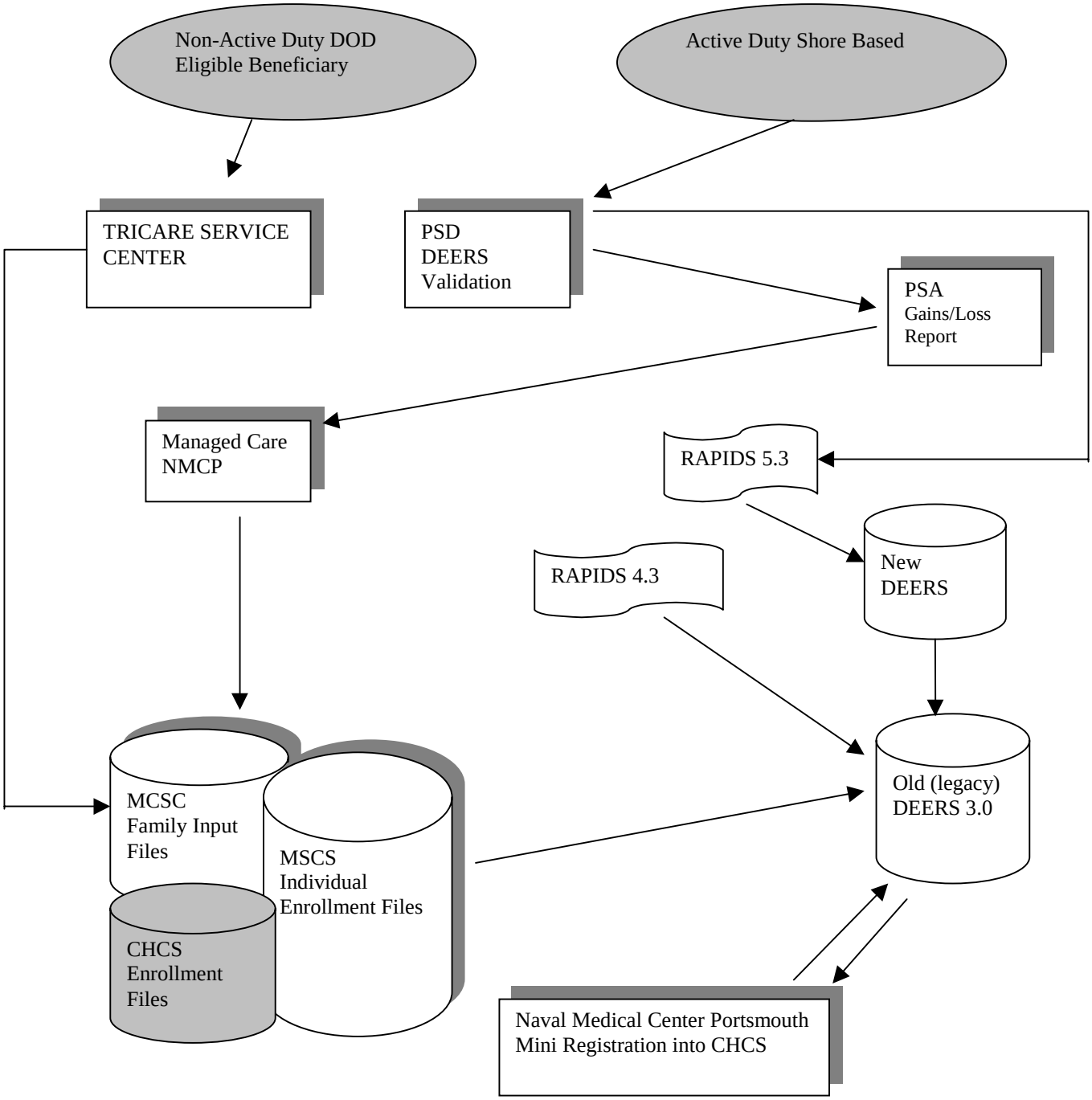
Lead Agent
Military Treatment Facilities

Naval Medical Center Portsmouth, Virginia
McDonald ACH - FT. Eustis, Virginia
1st Medical Group – Langley, Virginia
Kenner ACH – FT. Lee, Virginia
4th Medical Group – Seymour Johnson, North Carolina
Womack ACH – FT. Bragg, North Carolina
Naval Hospital Cherry Point, North Carolina
Naval Hospital Camp Lejeune, North Carolina

APPENDIX B

FLOW CHART – DEERS/CHCS ENROLLMENT TO THE TIDEWATER PLATFORM

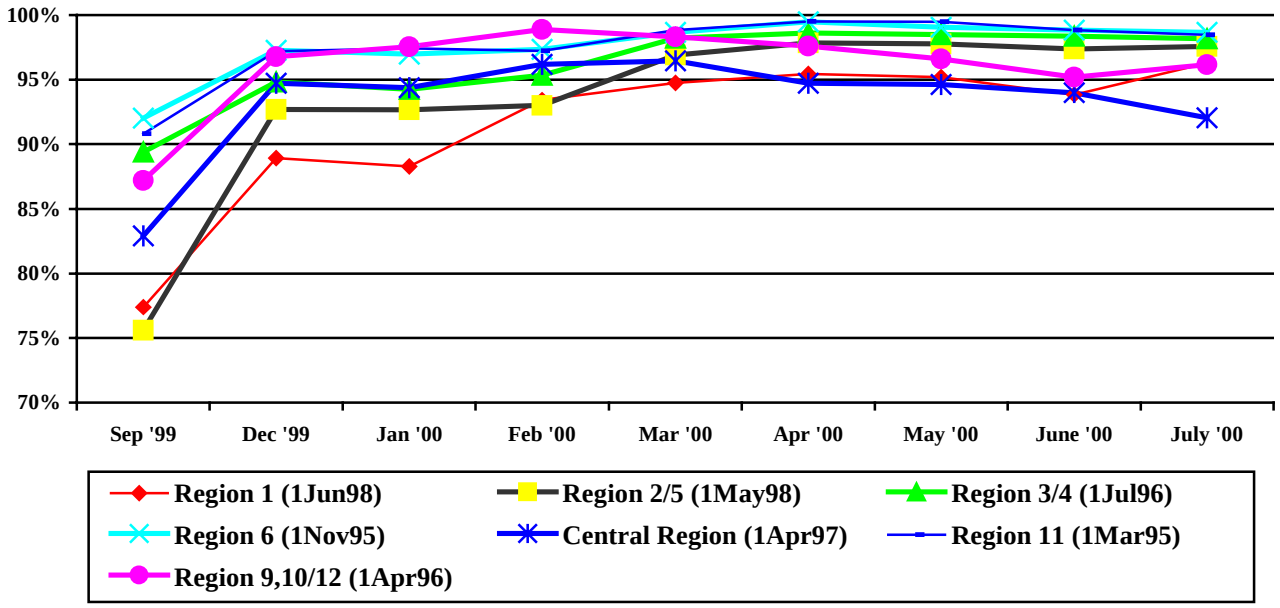
DEERS/CHCS ENROLLMENT TIDEWATER PLATFORM



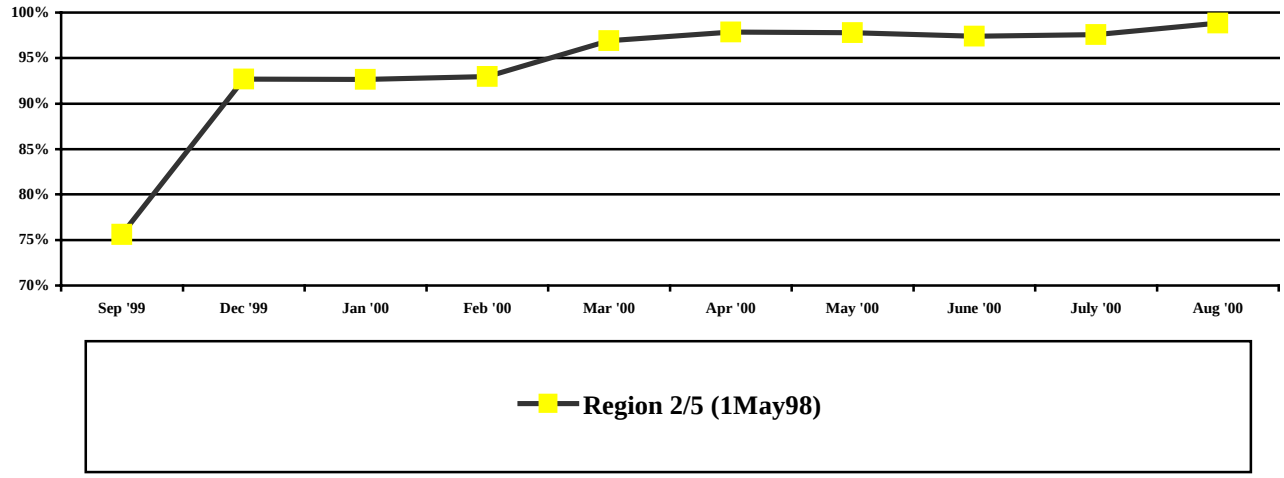
APPENDIX C

TRICARE CLAIMS PROCESSING PERFORMANCE POST IMPLEMENTATION OF NEW TIMELINESS STANDARD – ALL REGIONS AND COMBINED REGION 2 & 5

TRICARE CLAIMS PROCESSING PERFORMANCE ALL REGIONS
(% of Retained Claims Processed by the FI within 30 days - New Standard)



TRICARE CLAIMS PROCESSING PERFORMANCE COMBINED
TRICARE MID-ATLANTIC REGION 2 & HEARTLAND REGION 5
(% of Retained Claims Processed by the FI within 30 days - New Standard)



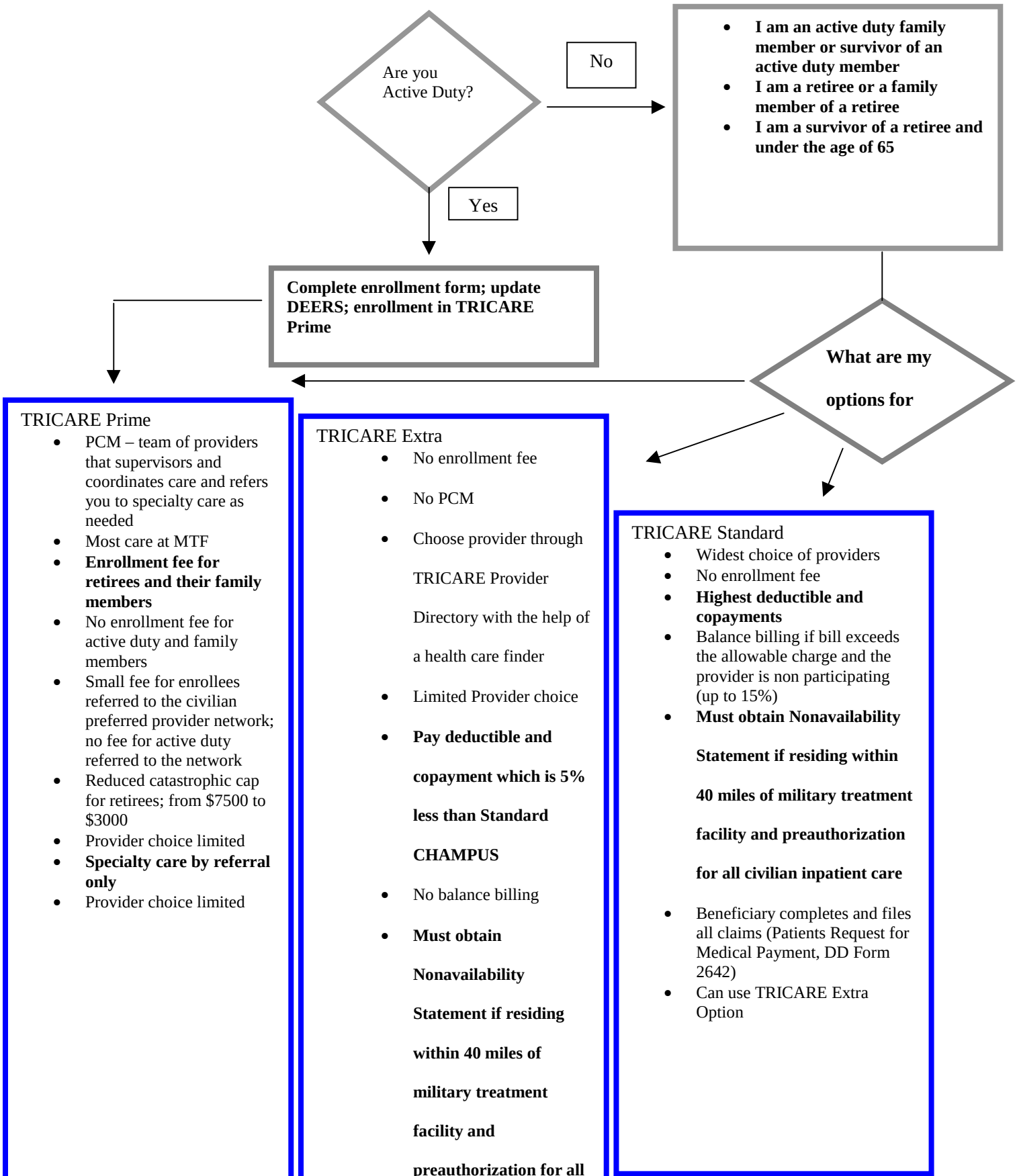
APPENDIX D

TRICARE TRIPLE HEALTH CARE OPTIONS

TRICARE BENEFITS AND COVERAGE CHART – OUTPATIENT SERVICES

TRICARE BENEFITS AND COVERAGE CHART – INPATIENT SERVICES

TRICARE TRIPLE HEALTH CARE OPTIONS



Benefits and Coverage Chart – Outpatient Services

	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Enrollment Fee	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	None None $230/person or $460/family	None	None
Annual Deductible	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	None (Except POS)	$50/person or $ $100/family $150/person or $300/family $150/person or $300/family	$50/person or $ $100/family $150/person or $300/family $150/person or $300/family
Individual Provider Services	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 6 copay $12 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Lab and X-Ray: Enhanced Preventive Benefits	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	No copay	Limited coverage	Limited coverage
Lab and X-Ray Services: Non-Preventive	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 6 copay $12 copay $12 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Routine Pap Smears	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	No copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Ambulance Services	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$10 copay $15 copay $20 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Home Health Care	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 6 copay $12 copay $12 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Family Health Services	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 6 copay $12 copay $12 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Retail Network Prescription Drugs Other than those purchased at MTF (30-day supply) (2)	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 5 copay $ 5 copay $ 9 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Durable Medical Equipment, Prosthetic Devices and Medical Supplies Prescribed by an Authorized Provider	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	10% of contracted fee 15% of contracted fee 20% of contracted fee	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Emergency Services	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$10 copay $30 copay $30 copay	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Outpatient Mental Health	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$10/ind. Visit $6/grp visit $20/ind. Visit $12/grp visit $25/ind. Visit $17/grp visit	15% of contracted fee 15% of contracted fee 20% of contracted fee	20% of TRICARE allowable 20% of TRICARE allowable 25% of TRICARE allowable
Clinical Exams	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	No copay	Limited coverage	Limited coverage
Immunizations Enhanced Preventive Service (1)	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	No copay	Limited coverage	Limited coverage
Immunizations Required for Overseas Travel for Active Duty Family	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 6 copay $12 copay Not covered	15% of contracted fee 15% of contracted fee Not covered	20% of TRICARE allowable 20% of TRICARE allowable Not covered
Eye Exams	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$ 6 copay $12 copay Not covered	15% of contracted fee 15% of contracted fee Not covered	20% of TRICARE allowable 20% of TRICARE allowable Not covered
Eye Exams: Enhanced Preventive Service (1)	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	No copay	Limited coverage	Limited coverage
Ambulatory Surgery	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$25 copay	$25 copay $25 copay 20% of contracted fee	$25 copay $25 copay 20% of TRICARE allowable
Partial Hospitalization For Alcoholism Treatment	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$20/day copay or $25 min.* $20/day copay or $25 min.* $40/day copay	$20/day copay or $25 min.* $20/day copay or $25 min.* 20% of contracted fee	$20/day copay or $25 min.* $20/day copay or $25 min.* 25% of contracted fee

(2) Please note that the amount paid will be the greater of the two values

(2) Clinical preventive services are either screening procedures to detect disease or primary or secondary prevention services to protect or restore health. These services may be provided during acute and chronic cares visits or during preventive care visits to maintain and promote good health.

(2) Outpatient deductible amounts do not apply to TRICARE Extra or Medicare BRAC prescription claims. For this benefit, deductibles apply only under TRICARE Standard.

NOTE: All outpatient co payments listed on this chart are applicable for treatment received outside the Military Treatment Facility. Any enrollment fees or annual deductibles are required regardless of where care is received. *All copays and cost shares are subject to change each fiscal year. Please check with a Beneficiary Service Representative for updated information.*

Benefits and Coverage Chart- Inpatient Services

	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
Hospitalization, Maternity, or Skilled Nursing Facility Care	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	$11/day copay or$25mim./admission* $11/day copay or$25mim./admission* $11/day copay or$25mim./admission*	$10.85/day or $25/admission* $10.85/day or $25/admission* $250 per day or 25% of institutional services plus 20% of professional charges	$10.85/day or $25/admission* $10.85/day or $25/admission* $390 per day or 25% of institutional services, whichever is less
Hospitalization for Mental Illness, Inpatient Treatment of Alcoholism, Partial Hospitalization-Mental Health	Family of E-4 and Below Family of E-5 and Above Retirees and Family Members	For information, please visit your local TRICARE Service Center or call: 1-800-93199501 (Mid-Atlantic Region) 1-800-941-4501 (Heartland Region)		
* Please note that the amount paid will be the greater of the two values and there are no separate co payments or cost shares for separately billed professional charges				

TRICARE Prime
Point-of-Service (POS) Option

I

Beneficiary Category	**Deductible**	**Cost-Share**
Active Duty Family Members	$300/individual $600/family	50% of TRICARE allowable charges
Retirees and Family Members	$300/individual $600/family	50% of TRICARE allowable charges

If you receive non-emergency services from a provider without a referral or authorization, you'll be required to pay higher cost shares and a deductible. This is called the Point-of-Service Option, and it is only available to TRICARE Prime enrollees. If you choose the Point-of-Service Option, there are some important things to remember.

- You will be responsible for an annual deductible of $300 for an individual and $600 for a family. This deductible applies to both inpatient and outpatient services and is applied to your fiscal year catastrophic cap, not an enrollment year Catastrophic cap. A fiscal year is October 1 through the following September 30.
- After you have met your deductible, you will be responsible for 50 percent of the TRICARE allowable charges. The TRICARE allowable charge is the amount a provider can charge you for a specific service; the charge will depend on the service provided.
- Also, you will be responsible for additional charges by the non-network provider. These charges, by law, can only be 15 percent higher than the TRICARE allowable charge. The Point-of-Service Option does not apply to emergency care; please review and understand the definition of emergency care in your TRICARE Prime Handbook.
- TRICARE reimbursement will be limited to 50% of the TRICARE allowable charges. Special rules apply limiting total reimbursement to 50% of the allowed charge when combined with a payment made by other primary Health Insurance

For Active Duty Families enrolled in TRICARE Prime, the maximum family liability (Catastrophic Cap Benefit) is $1,000 per fiscal year (October 1 through the following September 30); for all other Prime enrollees, the maximum family liability is $3,000 per enrollment year, unless you get care on your own without a referral from your TRICARE Prime Primary Care Manager and without an authorization from the Health Care Finder (using the Point-of-Service option). Point-of-Service medical expenses will not be "capped". For more details about cost caps, contact your local TRICARE Service Center.

APPENDIX E

ALL REGION SERVER BRIDGE DATA DICTIONARY
NETWORK NON-INSTITUTIONAL PROVIDERS

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line-item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
The Network Non-Institutional Table contains person-level claims data for all professional provider Health Care Standard Records (HCSR) claims reported to Ft. Detrick. The HCSR Non-Institutional claims include the professional provider component of the services related to an inpatient episode of care. The table provides monthly patient-level demographic, diagnosis procedure and cost data for medical care and treatment delivery by non-MHS professional providers. Monthly data, to include newly reported data and updates, is extracted from the Ft. Detrick HCSR Non-Institutional file.					
Amount Allowed, Raw	Total amount allowed for all authorized services (procedures, supplies, and drugs) as determined by the contractor. This field indicates the sum of the total amount for a particular query.		Integer		
Amount Allowed, Total	Total expected Amount Allowed when all claims have been processed. Raw Amount divided by the IBNR Factor		Integer		
Avg Amount Paid	Amount Paid by Government: The portion of the total amount allowed that was paid by the Government for the services reported. This field indicates the average of that total amount for a particular query.		Decimal (12,2)		
Avg Amount Allowed	Total amount allowed for all authorized services (procedures, supplies, and drugs) as determined by the contractor. This field indicates the average of that total amount for a particular query.		Decimal (12,2)		
Count Rows	Total number of unique records in a chosen query.		Integer		
Number of Visits, Raw	The sum of the number of treatment encounters with the provider for the medical and mental healthcare.		Integer		
Number of Visits, total	The expected Number of Visits when all claims have been processed, Raw Number of Visits divided by the IBNR Factor.		Integer		
Amount Paid, Raw	Amount Paid by Government: The portion of total amount allowed that was paid by the Government for the services reported. This field indicates the sum of the total amount that was paid by the gov't for a particular query.		Decimal (12,2)		
Amount Paid, Total	Total Amount Paid when all claims have been processed. Raw Amount Paid divided by the IBNR Factor.		Decimal (12,2)		
Amount Allowed, Raw	Total amount allowed for all authorized services (procedures, supplies, and drugs) as determined by the contractor. This field indicates the sum of the total amount for a particular query.		Integer		
Amount Allowed, Total	Total expected Amount Allowed when all claims have been processed. Raw Amount divided by the IBNR Factor.		Integer		

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
Avg Age	The Average age of the patient for a particular query based on the earliest begin date of care.		Integer		
Begin Date of Care	The earliest beginning date of the provider's services for this procedure.		Date Mm/dd/yyyy	e.g., 01/03/1999	
Ben Cat	Categorization of beneficiaries based on a given sponsor status for cost sharing and reporting purposes. For non-availability statements: categorizations for beneficiaries based on the sponsor's status and the patient's relationship to that sponsor.		Char (1)	1,2,3,4	1= active-dependent 2=retired-sponsor 3=retired/decreased-dependent and all other patients 4=active duty sponsor
CM	Calendar Month: Numeric code to identify the calendar month.	Derived from the end date of care.	Integer	1-12	1=January 2=February 3=March 4=April 5=May 6=June 7=July 8=August 9=September 10=October 11=November 12=December
CY	Calendar Year: Numeric Code representing the 12 month calendar year. Derived from the end date of care.	Derived from the end date of care	Integer (yyyy)	1998,1999	
DDS	DEERS Dependent Suffix; Code maintained by DEERS that uniquely identifies the patient within the family.		Char (2)	01-19,20,30-39,40-44,45-49,50-54, 55-59, 60-69, 70-74, 75, 98	01-19=Eligible Dependent Children 20=Sponsor 30-39=Spouse of Sponsor 40-44=Mother of Sponsor 50-54=Mother in Law of Sponsor 55-59=Father in Law of Sponsor 60-69=Other eligible Dependents (including former spouse) 70-74=Unknown by DEERS 75=Pseudo DDS unknown by contractor 98=Service Secretary Designee
End Date of Care	Latest date of care reported on the non-institutional for this reported claim.		Date Mm/dd/yy	e.g., 01/03/1999	
Enr DMIS Name	The name of the facility that corresponds with the DMIS Id.		Char(30)		Please Refer to Appendix D

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
Enr Parent DMIS ID	Code that identifies the parent DMIS Id, if the enrollment location is a clinic. Use this field to consolidate data for an MTF.		Char (4)		Please Refer to Appendix D
Enr Parent DMIS Name	The name of the facility that corresponds with the Parent DMIS Id.		Char(30)		Please Refer to Appendix D
Enrollment Command	Represents the intermediate service command of a military medical treatment facility. Derived from DMIS Table based on enrollment Dmis id.	Enrolling_division _DMIS_ID	Char(1)		Please Refer to Appendix H
Enrollment DMIS Id	Code that identifies the MTF where the beneficiary is currently enrolled.		Char(4)	e.g., 0036	Please Refer to Appendix D
Enrollment Mil Dep	Enrollment Military Department: military service perfoming the enrollment function. Derived from the DMIS Table, based on the enrollment DMIS Id		Char	A,C,F,N,S,X	A=Army C=Coast Guard F=Air Force N=Navy S=Non-catchment X=Civilian (USTF, MCSC, TPR); Unknown
Enrollment Region	Code that identifies the DoD Region associated with the Parent facility in which the beneficiary is enrolled.	EBC DEERS via Ft. Detrick	Char (2)	01-16, AK, EU, OS, S, TP, UK, X	01=Northeast 02=Mid-Atlantic 03=Southeast 04=Gulf South 05=Heartland 06=Southwest 07,08=TRICARE Central 09=Southern California 10=Golden Gate 11=Northwest 12, TP=TRICARE Pacific 13, EU=Germany 14,15, OS=OCONUS 16=Unknown AK=Alaska UK=United Kingdom S=Not Defined (Cases limited to DMIS 3031) X=Not Defined (Cased
Enrollment Status	Code indicating whether or not the patient is enrolled with the contractor		Char (2)	A-Z, AA, BB, SN	Please Refer to Appendix F

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
FM	Fiscal Month: Numeric code to identify a particular month the data is valid in the DoD fiscal year. Derived from the end date of care.		Integer	1-12	1=January 2=February 3=March 4=April 5=May 6=June 7=July 8=August 9=September 10=October 11=November 12=December
FY	Fiscal Year: Twelve month accounting period used by the federal gov't that begins on 01 Oct and ends 30 Sept and accounts for the year of discharge. Derived from the end date of care.		Integer (yyyy)	1998, 1999, 2000	
HCSR No	The number consisting of the ICN, time and suffix that uniquely identifies a HCSR		Char (21)		
Health Service Region	A health service region defined by zip codes of where the patient lives. The health service regions are twelve geographic regions of the United States, plus Puerto Rico, assigned a lead agent to uniformly implement the managed care concept through the Department of Defense.		Char (2)	01-12, AK, PR	01=CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT, VA*, WV* 02=NC, VA* 03=GA*, SC, FL* 04=AL, FL*, GA*, LA*, MS, TN 05=IL, IN, KY, MI, MO*, OH, WV*, WI 06=AR, LA*, OK, TX* 07=AZ*, MW, M, TX* 08=CO, ID*, IA, KS, MN, MO*, MT, NE, ND, SD, UT, WY 09=AZ*, Southern CA 10=Northern CA 11=ID*, OR, WA 12=HI AK=AK PR=PR *Shared with another region.
IBNR Factor	The percentage of claims normally received within this lag period. The calculated factor used to adjust the claims reported to date.		Decimal (5 places)		INBR Factor is derived using the Weibull Model: y=a-b*exp(-c*x^d), where a= 0.9914; b=1.3938; c=0.3617; d=0.927; x=age in months

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
IBNR Lag	The number of months lag between the Lag Ref Date and the data reporting date		Integer		
Lag Ref Date	This date shows the last period from which new data was transmitted to the current table in the Bridge. The lag reference date pulled from the data currency table, used to calculate the lag date between the date of service and the data reporting date.		Date mm/dd/yyyy		
Multiple Provider Id	Identification number that uniquely identifies individual providers using the same taxpayer identification number (TIN).		Char (4)	e.g., ZF23	
Number of Visits, Raw	The sum of the number of treatment encounters with the provider from medical and mental healthcare.		Integer		
Number of Visits, Total	Total expected Number of Visits when all claims have been processed. Raw Number of Visits divided by the IBNR Factor.		Integer		
Patient Age	HCSR definition: Age of patient calculated based on earliest begin date of care versus patient's date of birth		Integer		
Patient DOB	Patient's date of birth	DEERS, if available. Otherwise from health care data recorded by contractor	Date (8) mm/dd/yyyy	e.g., 01/03/1999	
Patient Gender	Patient/beneficiary Gender		Char (1)	M,F	M=Male F=Female
Patient Name	Legal name of patient downloaded from DEERS. (If unavailable from DEERs, utilize from the health care data submitted to contractor) The last name is at least two characters followed by a comma.		Char (27)	eg. HENRY,JOHN,C	All Capital Letters, no spaces, comma included ater last name, also after first name if middle initial exists.
Patient Zip	First five digits of US Postal zip code or foreign country code for patient's legal residence at the time the service was rendered. Must not be the zip code of a PO Box		Char (5)		

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

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Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
Place of Serv	Code to indicate the place of provided health care		Char (2)	00, 11, 12, 21-26, 31-34, 41, 42, 51-56, 61, 62, 65, 71, 72, 81, 99	00=Unassigned 11=Office 12=Home 21=Inpatient Hospital 22=Outpatient Hospital 23= Emergency Room Hospital 24=Ambulatory Hospital 25=Birthing Center 26=Military Treatment Facility 31=Doctors Office 32=Nursing Facility 33=Custodial Care 34=Hospice 41=Ambulance-Land 42=Ambulance-Air 51=Inpatient Psych 52=Psych Facility 53=Community Mental 54=Intermediate Care-Mental Health 55=Residential Substance Abuse 56=Psych Res Treatment Center 61=Comp Inpatient Rehab Facility 62=Comp Outpatient Rehab Facility 65=End Stage Renal Disease 71=State/Local Public Health 72=Rural Health 81=Independent Lab 99=Other Unlisted Facility
Primary Diagnosis	The condition code established, after study, to be the major cause for the patient to obtain medical care as coded on the UB-82 or otherwise indicated by the provider		Char (6)	No Decimal	The ICD-ED-NBR element specifies the diagnosis code manual for the code values.
Procedure Code	Code identifying principal procedure performed during the period covered by this HCSR as coded on the HCFA 1500 form.		Char (5)	e.g., 99222	
Program Ind Code	Identifies to which CHAMPUS program the services being reported on the HCSR are related		Char (1)	D, H, I, N, T	D=Drug H=Program for the Handicapped I=Institutional (excluding D, H and T) N=Non-Institutional (excluding D, H and T) T=Dental (excluding D and H)

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
Provider Specialty	Identifies provider's major specialty for noninstitutional providers		Char (2)	01-08, 10-11, 13-14, 16, 18-20, 22, 24-26, 28-30, 33-40, 42-49, 50, 51, 57, 59, 60, 64, 65, 69, 70, 80, 86, 88, 90-99, BC, HB, HA, HH, TS	Please Refer to Appendix E
Provider Tax ID	The IRS Taxpayer Identification Number (TIN) assigned to the institution/provider supplying the care.		Char (9)		
Provider Zip	The first five digits of the zip code of the location where the care was provided.		Char (5)		
Sec Diagnosis 1	Code describing additional diagnosis of conditions that co-exist at the time of admission.		Char (6)	No Decimal	
Sec Diagnosis 2	Code describing additional diagnosis of conditions that co-exist at the time of admission.		Char (6)	No Decimal	
Sec Diagnosis 3	Code describing additional diagnosis of conditions that co-exist at the time of admission.		Char (6)	No Decimal	
Sec Diagnosis 4	Code describing additional diagnosis of conditions that co-exist at the time of admission.		Char (6)	No Decimal	

NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
Serv Nature	Code indicating the nature of the type of service.Referred to as		Char (1)	1-9, A-L	1=Medical Care 2=Surgery 3=Consultation 4=Diagnostic/Therapeutic X-Ray 5=Diagnostic Laboratory 6=Radiation Therapy 7=Anesthesia 8=Assistance at Surgery 9=Other Medical Service A=DME Rental/Purchase B=Drugs C=Ambulatory Surgery D=Hospice E=Second Opinion on Elective Surgery F=Maternity G=Dental H=Mental Health Care I=Ambulance J=Program for Persons with Disabilities K=Physical/Occupational Therapy L=Speech Therapy
Service Type Code	The first of two codes used to indicate the type of service provided		Char (1)	A, C, I, K, O, M, P, N	A=Ambulatory surgery cost-share as inpatient (Active Duty Only) C=Air Force CAM Primary/Preventative Outpatient (effective prior to 04/97) I=Inpatient K=Emergency Room Admission cost shared as inpatient O=Outpatient - excluding M,P, or N, below M=Outpatient maternity cost-shared as inpatient P=Outpatient partial psychiatric hospitalization N=Outpatient cost-shared as inpatient
Sponsor Branch Svc	Sponsor's uniformed service branch or organization that creates entitlement to the health care.		Char(1)	A, E, F, I, M, N, P, C	A=Army E=Public Health Service F=Air Force I=NOAA M=Marines N=Navy P=Coast Guard C=CHAMPVA (Denied CHAMPVA claims after 1/1/96)

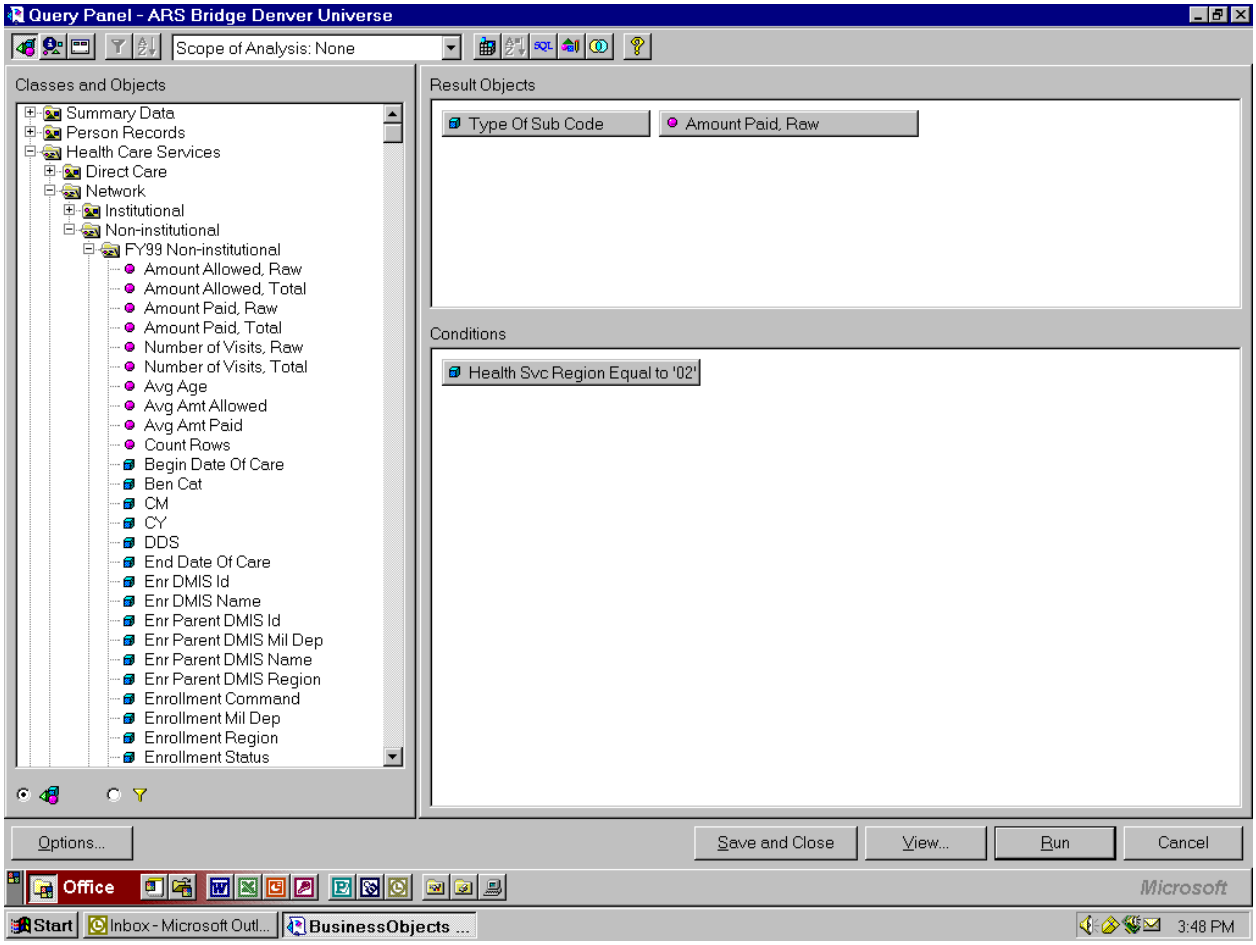
NETWORK—NON-INSTITUTIONAL (PROFESSIONAL SERVICES) FILE

Field	Definition	Source	Format	List of Values	Definition of Values/Notes
Data Limitations: Claims for all enrollees are included. However, records with no government liability (zero government paid out) are not included in the Bridge.					
Special Comments: Each line item billed on a claim us a separate record in this file. Definition of values may not be complete for all fields. Values not defined in this data dictionary may be contained in the on-line ADP manual, Chapter 2, maintained by TMA-Aurora, at www.tricare.ha.osd.mil. Notify the Customer Service Center of incomplete or missing definitions.					
Sponsor Pay Grade	Sponsor's pay grade code		Char (2)	00-09, 10, 11-15, 19, 20, 21-31, 40, 41-58, 90, 95, 99	00=Deleted 7/3/97 - Unknown Enlisted 01-09=Enlisted (E1-E9) 10=Deleted 7/3/97 - Unknown Warrant Officer 11-15=Warrant Officer (W1-W4) 19=Academy or Navy OCS Students 20=Unk Officer 21-31=Officer (01-011) 40=Deleted 7/3/97 - Unknown Civil Service 41-58=GS1-GS18 90=Unknown 95=Not Applicable 99=Other
Sponsor SSN	Sponsor social security account number or Veterans Adminstration file number		Char (9)		
Type of Sub Code	Code indicating the HCSR submission type		Char (1)	A, B, C, D, E, F, G, I, O, R	A=Adjustment to prior HCSR data B=Adjustment to Non-HCSR data C=Complete cancellation of prior HCSR data D=Complete FI/contractor denial initial HCSR submission E=Complete cancellation of Non-HCSR data F=Adjustment to prior HCSR data, additional HCSR suffix G=Additional DRG interim billing I=Initial HCSR Submission O=Zero payment HCSR due to 100% reimbursement by OHI-third party liability R=Resubmission of an initial HCSR that was rejected due to errors

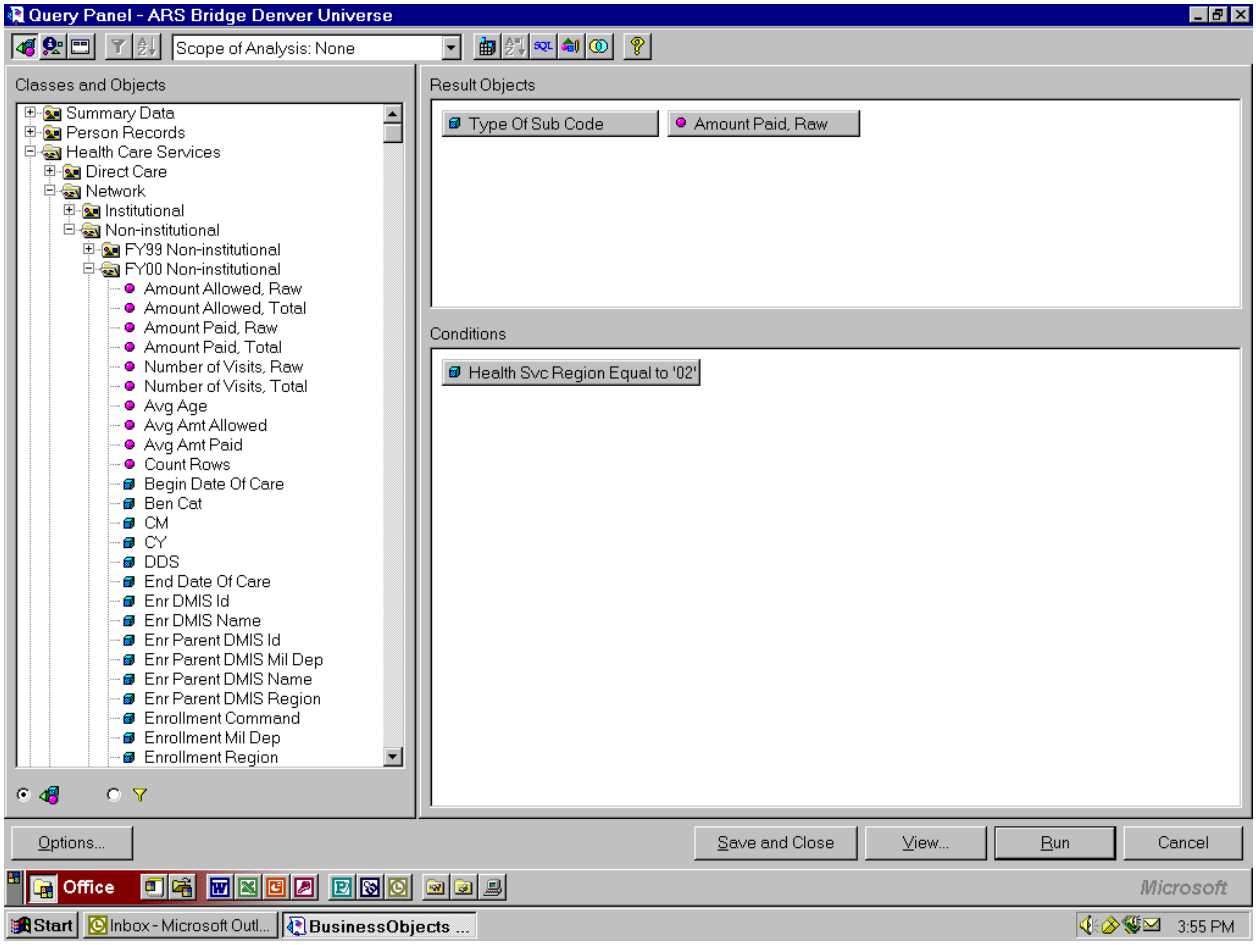
APPENDIX F

ALL REGION SERVER BRIDGE QUERY & SUMMARY RUN-TOTAL HEALTH CARE SERVICES FOR NETWORK NON-INSTITUTIONAL PROVIDERS REGION 2, FY99

ALL REGION SERVER BRIDGE QUERY & SUMMARY RUN-TOTAL HEALTH CARE SERVICES FOR NETWORK NON-INSTITUTIONAL PROVIDERS REGION 2, FY00



FY 99 FISCAL YEAR 99 --RUN DATE 2/12/01		ALL CLAIMS REGION 2	
		Amount Paid, raw	% of total
A	Adjustments to prior HCSRS	9,567,937.19	4.55%
F	Adjustments to prior HCSRS, Additional HCSR suffix	852,703.74	0.41%
I	Initial HCSR submission	174,562,577.14	83.03%
O	Zero payment HCSR due to 100% reimbursements by OHI third party liability	0.00	0.00%
R	Resubmission of an initial HCSR that was rejected due to errors	25,261,467.77	12.02%
	Total	210,244,685.84	

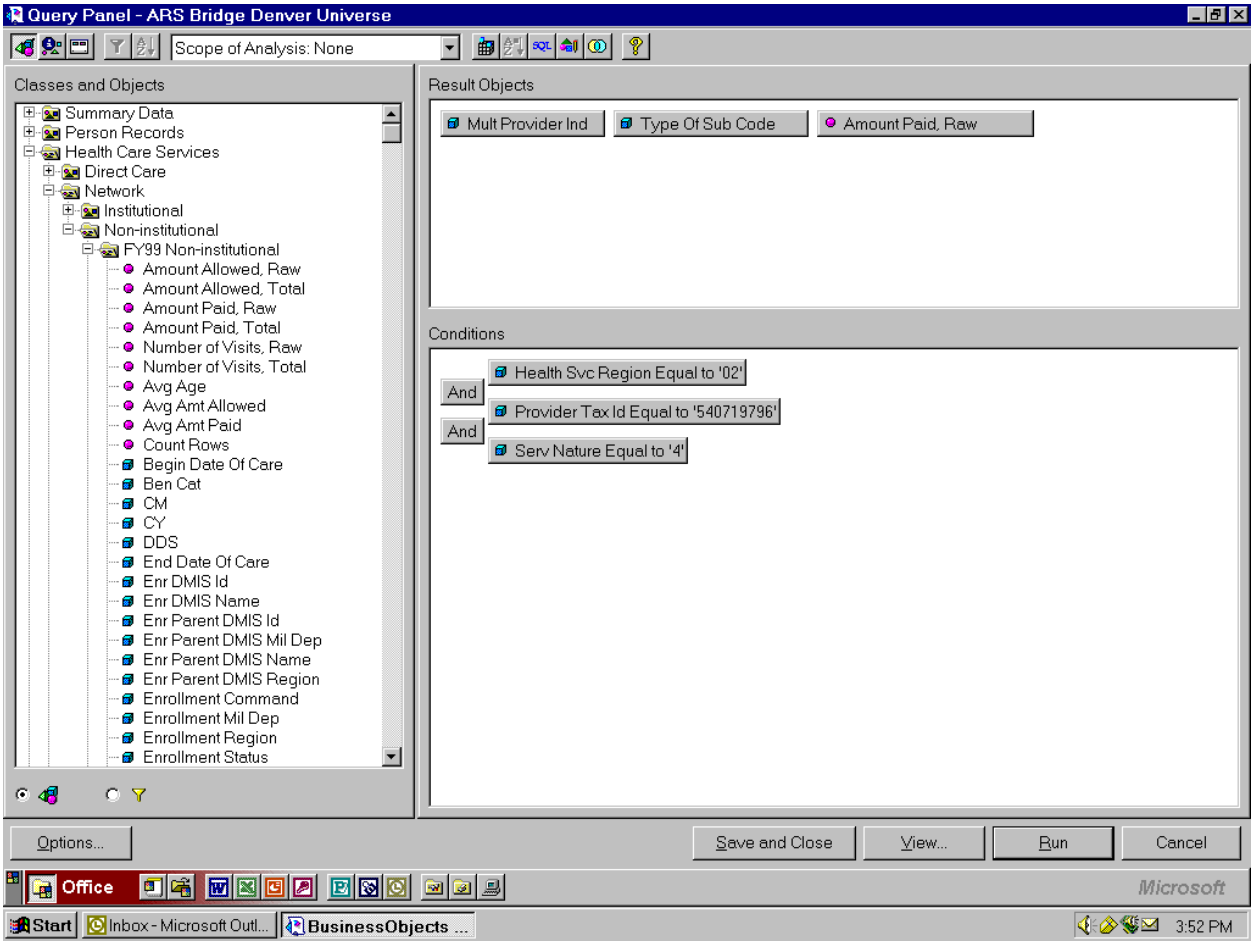


FY 00	FISCAL YEAR 00 --RUN DATE 2/12/01	ALL CLAIMS REGION 2	
		Amount Paid, raw	% of total
A	Adjustments to prior HCSRS	6,098,609.00	2.87%
F	Adjustments to prior HCSRS, Additional HCSR suffix	445,067.26	0.21%
I	Initial HCSR submission	181,055,356.51	85.12%
O	Zero payment HCSR due to 100% reimbursements by OHI third party liability	0.00	0.00%
R	Resubmission of an initial HCSR that ws rejected due to errors	25,106,311.55	11.80%
	Total	212,705,344.32	

APPENDIX G

ALL REGION SERVER BRIDGE QUERY & SUMMARY RUN-TOTAL HEALTH CARE SERVICES FOR NETWORK RADIOLOGY GROUP REGION 2, FY99

FY 99 NETWORK INSTITUTIONAL CLAIMS – RADILOGY GROUP



FY 99 FISCAL YEAR 99 --RUN DATE 2/12/01		Radiology Group	
		Radiology Group	% of total
A	Adjustments to prior HCSRS	2,827.02	1.01%
F	Adjustments to prior HCSRS, Additional HCSR suffix	701.97	0.25%
I	Initial HCSR submission	249,494.22	89.25%
O	Zero payment HCSR due to 100% reimbursements by OHI third party liability	0.00	0.00%
R	Resubmission of an initial HCSR that was rejected due to errors	26,520.97	9.49%
	Total	279,544.18	

C:\Program Files\Business Objects\BusinessObjects 5.0\Template\CEIS.bmp		
FOR OFFICIAL USE ONLY - May contain regulated medical data		
FY 99 network non- institutional claims-Radiology Group		
Type Of Sub Code	**Mult Provider Ind**	**Amount Paid, Raw**
A	A002	$150.13
	A003	$0.00
	A007	$289.74
	A008	$26.65
	A011	$25.67
	A012	$54.31
	A015	$174.36
	A018	$14.32
	A021	$56.20
	A023	$22.40
	A026	$177.91
	A031	$23.28
	A032	$51.27
	A037	$39.73
	A038	$61.60
	A039	$15.80
	A042	$107.81
	A044	$0.00
	A045	$32.24
	A046	$180.48
	A049	$8.85
	A052	$41.19
	A057	$15.64
	A062	$189.87
	A067	$66.89
	C002	$42.91
	C009	$47.21
	C010	$81.74
	C011	$425.88
	C018	$16.02
	C021	$10.88
	C025	$0.13
	C027	$15.20
	C028	$12.51
	C038	$121.96
	C043	$23.37
	E008	$79.02
	E016	$15.83
	E017	$17.56
	E018	$49.80
	E020	$40.66

A	**Sum:**	**$2,827.02**
FY99 Radiology Group		
Type Of Sub Code	**Mult Provider Ind**	**Amount Paid, Raw**
F	A015	$232.04
	A018	$10.72
	A042	$41.27
	A045	$74.74
	A057	$29.93
	A062	$69.13
	C005	$95.68
	C007	$25.70
	C012	$6.95
	E008	$115.81
F	**Sum:**	**$701.97**
Type Of Sub Code	**Mult Provider Ind**	**Amount Paid, Raw**
I	A001	$705.51
	A002	$13,236.41
	A003	$6,770.24
	A004	$10,847.42
	A005	$164.45
	A006	$799.05
	A007	$7,486.10
	A008	$5,136.00
	A009	$1,844.16
	A010	$1,173.18
	A011	$6,570.55
	A012	$8,579.08
	A013	$284.61
	A014	$17.37
	A015	$15,839.04
	A016	$1,843.37
	A017	$273.15
	A018	$10,159.72
	A019	$4,380.13
	A020	$546.77
	A021	$4,548.71
	A022	$4,664.70
	A023	$4,208.47
	A024	$47.37
	A025	$284.35
	A026	$4,347.85
	A027	$46.79
	A028	$6,613.74
	A029	$235.42
	A030	$369.78

	A031	$919.28
	A032	$1,065.90
	A033	$114.99
	A034	$65.48
	A035	$585.71
	A036	$376.32
FY99 Radiology Group	A037	$1,725.88
	A038	$9,571.54
	A039	$2,528.60
	A040	$632.47
	A041	$57.49
	A042	$7,514.76
	A043	$240.55
	A044	$2,474.69
	A045	$10,795.56
	A046	$6,231.63
	A047	$3,313.55
	A049	$1,273.40
	A050	$1,469.63
	A051	$3,801.12
	A052	$1,601.61
	A057	$17,063.51
	A058	$283.56
	A059	$4,527.28
	A060	$1,875.23
	A061	$698.80
	A062	$14,794.68
	A063	$4,105.54
	A065	$141.23
	A066	$1,793.67
	A067	$3,119.08
	A068	$1,993.36
	A069	$0.00
	B001	$143.35
	B003	$50.75
	B006	$0.00
	B007	$6.13
	B008	$42.28
	B044	$6.76
	C001	$184.13
	C002	$306.96
	C003	$458.53
	C004	$355.84
	C005	$343.67
	C006	$424.25
	C007	$197.36
	C008	$233.87

	C009	$364.09
	C010	$149.32
	C011	$267.26
	C012	$1,015.82
	C013	$125.16
	C014	$99.21
	C015	$331.55
	C016	$130.64
	C017	$206.97
FY99 Radiology Group	C018	$203.17
	C020	$16.34
	C021	$643.07
	C022	$1.99
	C023	$113.04
	C024	$169.32
	C025	$928.82
	C026	$13.97
	C027	$403.18
	C028	$132.97
	C029	$56.62
	C030	$28.26
	C031	$39.28
	C032	$347.58
	C033	$15.09
	C034	$989.95
	C035	$257.84
	C036	$273.99
	C037	$404.76
	C038	$218.43
	C039	$282.70
	C041	$664.90
	C042	$328.69
	C043	$131.96
	C046	$961.82
	C047	$143.80
	C048	$116.06
	C051	$14.03
	C054	$61.48
	C055	$36.85
	C056	$40.87
	C063	$227.14
	C071	$12.66
	D001	$46.51
	D003	$28.25
	D005	$9.11
	D010	$0.00
	E001	$113.45

	E006	$714.77
	E007	$97.41
	E008	$1,345.25
	E014	$0.00
	E015	$88.73
	E016	$678.62
	E017	$962.39
	E018	$872.35
	E020	$1,756.42
	E024	$0.00
	E029	$17.38
	E031	$175.45
FY99 Radiology Group	E035	$3.19
	E038	$80.82
I	**Sum:**	**$249,494.22**
Type Of Sub Code	**Mult Provider Ind**	**Amount Paid, Raw**
O	A004	$0.00
	A006	$0.00
	A007	$0.00
	A010	$0.00
	A027	$0.00
	C023	$0.00
	C026	$0.00
	C034	$0.00
	C037	$0.00
	C063	$0.00
	E006	$0.00
	E008	$0.00
	E020	$0.00
O	**Sum:**	**$0.00**
Type Of Sub Code	**Mult Provider Ind**	**Amount Paid, Raw**
R	A001	$122.03
	A002	$1,462.73
	A003	$190.07
	A004	$943.06
	A007	$1,797.67
	A009	$214.75
	A010	$20.25
	A011	$736.99
	A012	$1,195.45
	A014	$0.00
	A015	$923.50
	A016	$343.38
	A018	$599.34
	A019	$242.77

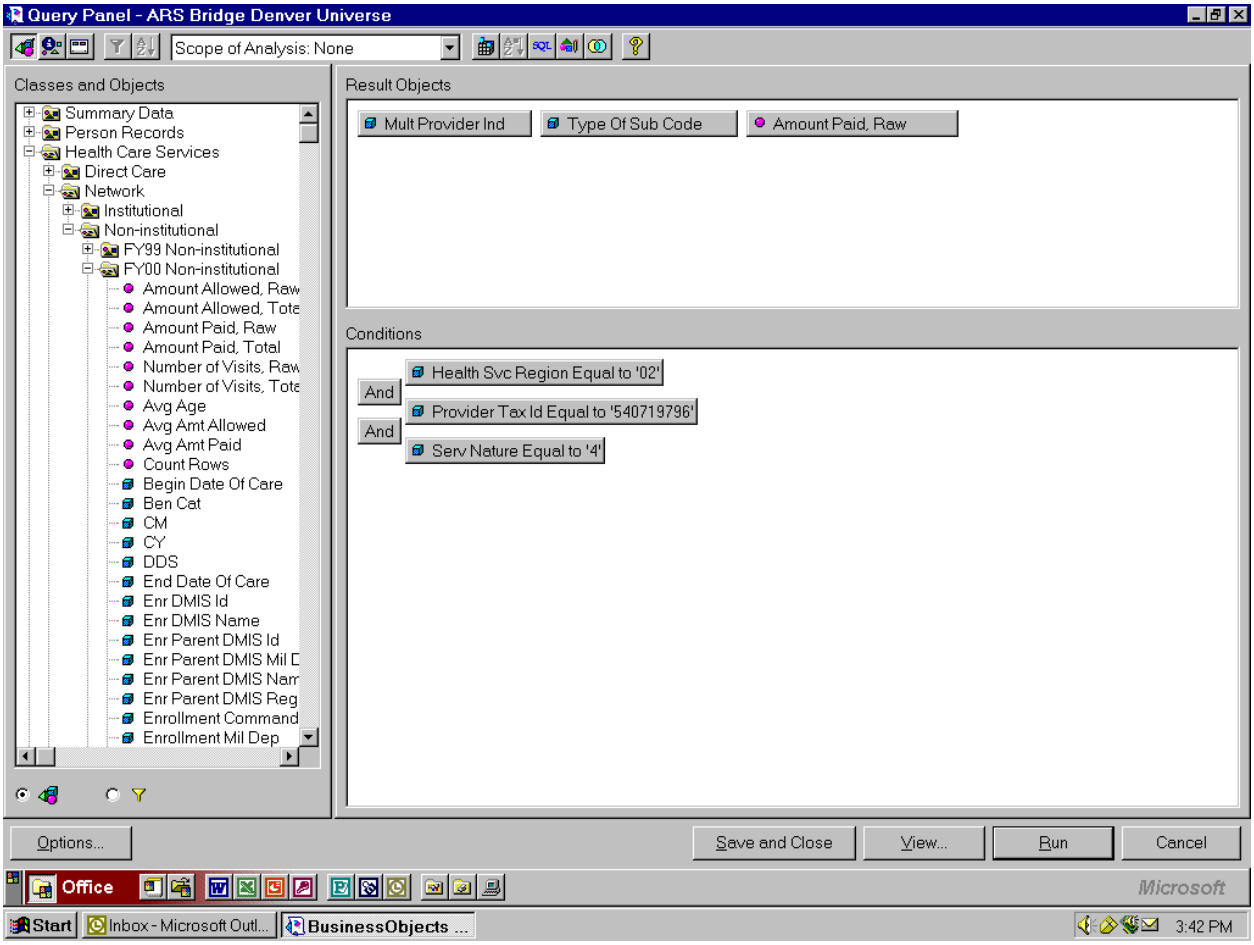
	A020	$30.95
	A021	$1,132.26
	A022	$41.15
	A023	$297.60
	A025	$41.02
	A026	$354.94
	A028	$418.46
	A029	$64.60
	A030	$7.17
	A031	$10.38
	A032	$99.42
	A033	$0.00
	A034	$90.38
	A035	$2.21
	A036	$87.57
FY99 Radiology Group	A037	$226.38
	A038	$928.20
	A039	$357.72
	A040	$170.11
	A042	$1,364.85
	A043	$68.26
	A044	$584.21
	A045	$676.98
	A046	$384.56
	A047	$236.21
	A049	$108.99
	A050	$464.83
	A051	$404.80
	A052	$102.17
	A057	$1,651.79
	A059	$715.95
	A060	$10.72
	A061	$21.44
	A062	$1,213.11
	A063	$517.08
	A066	$233.60
	A067	$245.63
	A068	$8.12
	B001	$34.13
	B006	$12.94
	B009	$10.72
	B021	$291.50
	C003	$41.27
	C005	$187.27
	C006	$76.85
	C008	$7.40
	C009	$42.78

	C012	$110.33
	C013	$8.75
	C014	$8.78
	C015	$149.75
	C016	$8.45
	C017	$127.81
	C020	$8.66
	C021	$167.71
	C022	$176.93
	C023	$150.63
	C024	$7.40
	C025	$8.34
	C026	$47.57
	C027	$21.23
	C031	$39.25
	C032	$197.91
	C034	$189.74
	C035	$7.71
FY99 Radiology Group	C037	$8.78
	C038	$8.34
	C039	$44.95
	C041	$36.43
	C043	$165.05
	C046	$15.00
	C051	$41.02
	D001	$34.13
	E006	$118.30
	E008	$279.87
	E015	$8.69
	E016	$175.87
	E017	$61.73
	E018	$903.55
	E020	$311.64
	E038	$0.00
R	**Sum:**	**$26,520.97**
	Sum:	**$279,544.18**

APPENDIX H

ALL REGION SERVER BRIDGE QUERY & SUMMARY RUN-TOTAL HEALTH CARE SERVICES FOR NETWORK RADIOLOGY GROUP REGION 2, FY00

FY 00 NETWORK NON-INSTITUTIONAL CLAIMS – RADIOLOGY GROUP



FY 00	FISCAL YEAR 00 --RUN DATE 2/12/01	Radiology Group	
		Radiology Group	% of total
A	Adjustments to prior HCSRS	1,512.10	0.64%
F	Adjustments to prior HCSRS, Additional HCSR suffix	297.61	0.13%
I	Initial HCSR submission	214,449.99	90.57%
O	Zero payment HCSR due to 100% reimbursements by OHI third party liability	0.00	0.00%
R	Resubmission of an initial HCSR that ws rejected due to errors	20,513.99	8.66%
	Total	236,773.69	

C:\Program Files\Business Objects\BusinessObjects 5.0\Template\CEIS.bmp		
FOR OFFICIAL USE ONLY - May contain regulated medical data		
FY 00 network non-institutional. Claims for Radiology Group		
Type Of Sub Code	Mult Provider Ind	Amount Paid, Raw
A	A004	$19.72
	A010	$7.48
	A012	$18.09
	A013	$17.20
	A015	$227.50
	A016	$1.66
	A021	$11.67
	A023	$8.75
	A026	$25.30
	A027	$7.13
	A028	$22.35
	A033	$18.13
	A037	$8.45
	A038	$79.47
	A039	$31.33
	A043	$27.06
	A045	$16.78
	A046	$123.63
	A047	$148.46
	A051	$102.91
	A060	$90.76
	A068	$4.47
	C004	$83.06
	C009	$16.03
	C011	$80.72
	C013	$3.00
	C026	$8.56
	C034	$37.83
	C037	$67.22
	C047	$7.28
	C055	$41.65
	E006	$59.83
	E016	$17.82
	E017	$34.92
	E029	$35.88
A	Sum:	$1,512.10
Type Of Sub Code	Mult Provider Ind	Amount Paid, Raw
F	A002	$168.78
	A016	$0.78
	A022	$6.82
	A038	$8.91
	A042	$8.78
	A045	$20.66
	A046	$36.35
	C005	$8.77
	C013	$1.62
	C023	$28.86
	E008	$7.28
F	Sum:	$297.61
Type Of Sub Code	Mult Provider Ind	Amount Paid, Raw
I	A002	$6,693.67

	A003	$4,440.16
	A004	$6,017.94
	A005	$120.97
	A006	$103.33
	A007	$1,481.01
	A008	$2,035.86
FY00 Radiology Group	A009	$1,336.74
	A010	$539.16
	A011	$4,040.15
	A012	$5,576.11
	A013	$141.75
	A014	$297.24
	A015	$11,370.06
	A016	$1,117.92
	A017	$109.68
	A018	$5,936.04
	A019	$2,490.59
	A020	$29.66
	A021	$4,276.05
	A022	$2,345.79
	A023	$3,029.44
	A024	$119.90
	A025	$147.90
	A026	$3,476.42
	A027	$134.03
	A028	$4,595.54
	A029	$229.37
	A030	$100.67
	A031	$843.02
	A032	$484.02
	A033	$118.73
	A034	$22.73
	A035	$276.15
	A036	$113.20
	A037	$1,350.43
	A038	$7,242.12
	A039	$1,871.51
	A040	$254.04
	A041	$37.65
	A042	$3,582.52
	A043	$151.10
	A044	$2,177.15
	A045	$6,894.56
	A046	$4,049.36
	A047	$1,768.44
	A048	$8.12
	A049	$647.11
	A051	$3,450.26
	A052	$1,474.72
	A057	$6,151.18
	A060	$1,246.08
	A061	$559.98
	A062	$5,022.53
	A063	$3,381.94
	A065	$63.87
	A066	$1,638.25
	A067	$4,377.96
	A068	$3,754.03
	A069	$49.30
	A071	$267.35
	A072	$791.87

	B001	$21.44
	B006	$80.26
	B008	$8.73
	B009	$4.30
	B010	$0.00
	B019	$0.00
	C002	$1,794.01
	C003	$1,541.83
	C004	$1,842.79
	C005	$1,916.99
	C006	$310.29
FY00 Radiology Group	C007	$3,440.84
	C008	$176.01
	C009	$2,078.50
	C010	$487.42
	C011	$1,120.38
	C012	$2,288.97
	C013	$1,362.25
	C014	$325.87
	C015	$266.24
	C016	$26.75
	C017	$295.08
	C020	$152.60
	C021	$66.77
	C022	$3.39
	C023	$1,147.12
	C024	$789.22
	C025	$144.21
	C026	$1,590.46
	C027	$506.82
	C028	$1,061.25
	C029	$1,001.70
	C030	$32.97
	C031	$2,124.94
	C032	$106.60
	C034	$1,229.90
	C035	$11.25
	C036	$2,005.14
	C037	$475.56
	C038	$682.17
	C039	$95.15
	C041	$227.57
	C042	$439.39
	C043	$362.30
	C046	$251.06
	C047	$3,131.83
	C048	$836.21
	C050	$10.96
	C051	$1,476.28
	C052	$2,534.64
	C053	$158.58
	C054	$191.18
	C055	$1,351.15
	C056	$1,169.96
	C058	$291.61
	C060	$308.54
	C062	$1,255.74
	C063	$191.64
	C065	$1,782.20
	C071	$57.26
	C074	$14.64

	D003	$0.00
	D005	$1.17
	D006	$10.89
	D010	$0.00
	D011	$2.41
	D012	$9.40
	D018	$0.68
	D022	$5.12
	D031	$13.70
	D033	$6.13
	D041	$8.66
	E004	$52.49
	E005	$14.20
	E006	$6,650.15
	E008	$5,357.08
	E015	$147.80
FY00 Radiology Group	E016	$3,077.58
	E017	$5,457.96
	E018	$2,972.92
	E020	$4,263.00
	E024	$23.17
	E028	$61.58
	E029	$173.54
	E034	$82.80
	E035	$691.06
	E038	$253.16
I	Sum:	$214,449.99
Type Of Sub Code	Mult Provider Ind	Amount Paid, Raw
O	A002	$0.00
	A003	$0.00
	A004	$0.00
	A005	$0.00
	A006	$0.00
	A007	$0.00
	A008	$0.00
	A009	$0.00
	A010	$0.00
	A011	$0.00
	A012	$0.00
	A013	$0.00
	A014	$0.00
	A015	$0.00
	A016	$0.00
	A017	$0.00
	A019	$0.00
	A020	$0.00
	A021	$0.00
	A022	$0.00
	A023	$0.00
	A024	$0.00
	A025	$0.00
	A026	$0.00
	A027	$0.00
	A028	$0.00
	A029	$0.00
	A030	$0.00
	A031	$0.00
	A032	$0.00
	A033	$0.00
	A034	$0.00

	A035	$0.00
	A036	$0.00
	A037	$0.00
	A038	$0.00
	A039	$0.00
	A040	$0.00
	A042	$0.00
	A043	$0.00
	A044	$0.00
	A045	$0.00
	A046	$0.00
	A047	$0.00
	A062	$0.00
	A067	$0.00
	A068	$0.00
	C002	$0.00
	C003	$0.00
	C004	$0.00
	C005	$0.00
	C006	$0.00
	C008	$0.00
FY00 Radiology Group	C010	$0.00
	C011	$0.00
	C012	$0.00
	C013	$0.00
	C014	$0.00
	C015	$0.00
	C016	$0.00
	C017	$0.00
	C020	$0.00
	C023	$0.00
	C024	$0.00
	C025	$0.00
	C026	$0.00
	C027	$0.00
	C028	$0.00
	C029	$0.00
	C031	$0.00
	C034	$0.00
	C035	$0.00
	C036	$0.00
	C037	$0.00
	C038	$0.00
	C039	$0.00
	C041	$0.00
	C042	$0.00
	C046	$0.00
	C047	$0.00
	C048	$0.00
	C051	$0.00
	C052	$0.00
	C053	$0.00
	C055	$0.00
	C056	$0.00
	C058	$0.00
	C060	$0.00
	C062	$0.00
	C063	$0.00
	C065	$0.00
	D004	$0.00
	D005	$0.00

	D022	$0.00
	D033	$0.00
	D039	$0.00
	D041	$0.00
	E006	$0.00
	E008	$0.00
	E015	$0.00
	E016	$0.00
	E017	$0.00
	E020	$0.00
	E030	$0.00
O	Sum:	$0.00
Type Of Sub Code	Mult Provider Ind	Amount Paid, Raw
R	A001	$396.05
	A002	$538.58
	A003	$149.63
	A004	$240.88
	A007	$77.74
	A008	$40.93
	A010	$0.00
	A011	$191.42
	A012	$290.86
	A013	$33.62
	A015	$93.26
	A018	$206.37
FY00 Radiology Group	A021	$214.09
	A022	$266.38
	A023	$139.76
	A026	$40.97
	A027	$7.13
	A028	$112.75
	A029	$39.39
	A030	$33.87
	A033	$0.00
	A034	$54.71
	A035	$307.62
	A036	$147.31
	A037	$53.22
	A038	$443.76
	A039	$23.33
	A042	$132.65
	A045	$606.94
	A046	$430.79
	A047	$16.24
	A049	$117.06
	A050	$61.42
	A051	$276.59
	A052	$152.55
	A057	$88.04
	A061	$88.41
	A062	$109.29
	A063	$107.03
	A065	$86.96
	A066	$66.67
	A067	$104.09
	A068	$222.84
	A072	$823.63
	A073	$5.10
	B041	$0.00
	C002	$516.26

	C003	$227.24
	C004	$520.57
	C005	$420.34
	C007	$764.42
	C009	$142.18
	C010	$408.04
	C011	$71.87
	C012	$443.94
	C013	$540.25
	C015	$0.00
	C016	$32.74
	C017	$204.57
	C020	$10.50
	C022	$15.05
	C023	$318.15
	C024	$355.08
	C025	$43.96
	C026	$161.95
	C027	$15.04
	C028	$322.35
	C029	$124.26
	C031	$504.18
	C034	$182.24
	C036	$440.07
	C037	$239.10
	C038	$215.75
	C041	$117.84
	C042	$15.90
	C046	$59.80
	C047	$332.01
	C048	$91.95
FY00 Radiology Group	C051	$384.36
	C052	$210.81
	C053	$91.03
	C054	$220.62
	C055	$452.72
	C056	$501.83
	C058	$478.91
	C060	$78.79
	C062	$410.86
	C063	$22.20
	C065	$256.67
	C071	$117.68
	C074	$33.68
	D030	$6.58
	E004	$15.74
	E006	$561.11
	E008	$294.67
	E015	$17.56
	E016	$258.17
	E017	$197.00
	E018	$189.66
	E020	$78.45
	E027	$35.74
	E035	$13.47
	E038	$80.13
	E044	$8.02
R	Sum:	$20,513.99
	Sum:	$236,773.69

APPENDIX I

SUMMARY COMPARISON: ALL CLAIMS REGION 2 FOR FY 99 AND FY 00 COMPARED WITH A PARTICULAR RADIOLOGY GROUP IN REGION 2

SUMMARY COMPARISON: STATUS OF ALL CLAIMS REGION 2 FY 99 AND FY00 COMPARED WITH THE STATUS OF CLAIMS FOR A PARTICULAR RADIOLOGY GROUP IN REGION 2

FY 99 FISCAL YEAR 99 --RUN DATE 2/12/01		ALL CLAIMS REGION 2		Radiology Group	
		Amount Paid, raw	% of total	Radiology Group	% of total
A	Adjustments to prior HCSRS	9,567,937.19	4.55%	2,827.02	1.01%
F	Adjustments to prior HCSRS, Additional HCSR suffix	852,703.74	0.41%	701.97	0.25%
I	Initial HCSR submission	174,562,577.14	83.03%	249,494.22	89.25%
O	Zero payment HCSR due to 100% reimbursements by OHI third party liability	0.00	0.00%	0.00	0.00%
R	Resubmission of an initial HCSR that was rejected due to errors	25,261,467.77	12.02%	26,520.97	9.49%
	Total	210,244,685.84		279,544.18	

FY 00 FISCAL YEAR 00 --RUN DATE 2/12/01		ALL CLAIMS REGION 2		Radiology Group	
		Amount Paid, raw	% of total	Radiology Group	% of total
A	Adjustments to prior HCSRS	6,098,609.00	2.87%	1,512.10	0.64%
F	Adjustments to prior HCSRS, Additional HCSR suffix	445,067.26	0.21%	297.61	0.13%
I	Initial HCSR submission	181,055,356.51	85.12%	214,449.99	90.57%
O	Zero payment HCSR due to 100% reimbursements by OHI third party liability	0.00	0.00%	0.00	0.00%
R	Resubmission of an initial HCSR that ws rejected due to errors	25,106,311.55	11.80%	20,513.99	8.66%
	Total	212,705,344.32		236,773.69	